



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 7, 2024

Licensee
Berkeley Heights Homes LLC
1509 Sugarloaf Trail
Brooklyn Park, MN 55444

RE: Project Number(s) SL36852015

Dear Licensee:

On September 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 26, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 5, 2024

Licensee

Berkeley Heights Homes LLC

1509 Sugarloaf Trail

Brooklyn Park, MN 55444

RE: Project Number(s) SL36852015

Dear Licensee:

On July 3, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 26, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 26, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 26, 2024, found not corrected at the time of the July 3, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

0830-Local Laws Apply-144g.45 Subd. 3 - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on July 3, 2024 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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 may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

A state correction 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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

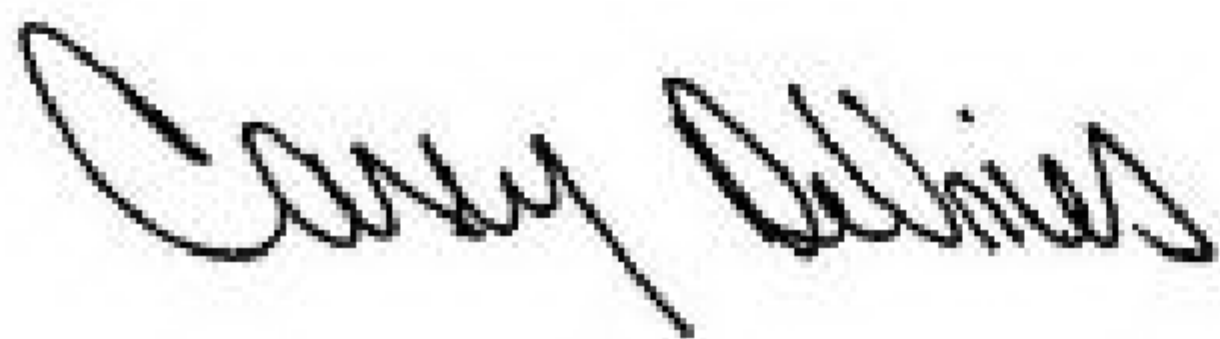
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/03/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36852015-1 On July 3, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 26, 2024. At the time of the survey, there were three residents; all of whom were receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued: 0800, 0810, 0820, and 0830.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	{0 480}			

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 3 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 4 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect the 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). Findings include: On July 3, 2024, at 9:35 a.m. on a revisit survey, staff toured the facility with administrator (A)-A, and the following maintenance issues were observed. 1. It was observed that in resident room #1 the vinyl flooring was coming up. Bottom of the window frame had signs of deterioration due to lack of maintenance. 2. It was observed in resident room #2 bottom of the window frame had sign of deterioration due to lack of maintenance. 3. It was observed in resident room #4 that the window frame had signs of deterioration due to lack of maintenance. The electric wall heater was	{0 800}			

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{0 800}	Continued From page 5 dented in. Multiple stains on the carpet. The room had a musty smell. 4. It was observed in bedroom #5 that the resident room door had holes in it. The carpet was loose and heavily stained. 5. Closet door in basement hallway had a hole in it. 6. Downstairs hallway carpet was torn and coming loose. This could cause a tripping hazard. 7. Main level bathroom wall trim was coming off. 8. Vent cover underneath kitchen sink was missing. 9. The vinyl flooring on the steps going up to the main level was coming up. 10. Laundry room window frame had sign of deterioration due to lack of maintenance. 11. Front concrete steps going into the front entrance were not steady and moved when stepped on them. 12. The wooden deck and patio in the back yard had signs of deterioration due to lack of maintenance. 14. The sheet rock under the garage door entrance to the house was missing sheet rock. 15. Crack in the header wall between the kitchen and living room. 16. Drawer in kitchen cabinet come unattached from the draw slides.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	{0 810}			

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{0 810}	Continued From page 6 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 810}			

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{0 810}	Continued From page 7 resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted via email on July 3, 2024, at 1:30 p.m. with administrator (A)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. The available documentation of the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan uses the RACE acronym which is very basic and does not show the employees actions in the event of a fire or similar emergency. The available documentation of the evacuation plan also did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan uses the RACE acronym which is very basic and does not show the residents actions in the event of a fire or similar emergency.	{0 810}			
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	{0 820}			

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{0 820}	Continued From page 8 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee had locking arrangements on the outside of resident room #4 this did not constitute a distinct hazard to life but had the potential to directly affect all residents and staff. 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). On July 3, 2024, at 9:35 a.m. survey staff toured the facility on a revisit with licensed administrator (A)-A. It was observed that resident room #4 had a latch style door lock on the outside of the resident's door. This was on the outside which would allow anyone in the facility to lock the door, trapping another person inside any of these rooms. Latch style door locks on the hallway side constituted an obstruction of egress and resident safety.	{0 820}			

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{0 830}	Continued From page 9	{0 830}			
{0 830} SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 3, 2024, but R4 had previously been admitted to the facility on June 4, 2023, under different ownership. R4's diagnoses included diabetes and schizoaffective disorder. On July 3, 2024, at 9:45 a.m., the surveyor observed the garage to contained two wood and fabric covered chairs, a mattress, and several containers of bagged garbage, as well as	{0 830}			

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{0 830}	Continued From page 10 miscellaneous furniture and stored items. The wooden and fabric chairs had burn marks on them, and there were several cigarette butts inside of a metal bucket located on the table and one cigarette butt located on the ground directly inside the garage by the table. The layout of the facility was a split-level residential home with a connecting garage. There were no fire extinguishers located in the garage. On July 3, 2024, at 9:45 a.m., R5 stated, "[R4] said she is the only one who smokes in the garage, everyone else smokes outside." On July 3, 2024, at 10:05 a.m., administrator (A)-A stated, "The expectation is that the resident will smoke in the back yard or on the deck, and we reemphasize that. Like right now she (R4) just went out there (into the garage) and she agreed to only wrap her cigarettes out there, but sometimes there is human nature and not everyone gets along so we continue to re-educate her because it is a fire risk and I need to look out for all the residents not just one, so re-direction, re-direction, re-direction is what we do." On July 3, 2024, at 10:12 a.m., the surveyor observed R4 stitting in the attached garage smoking a cigarette. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other	{0 830}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
(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	
{0 830}	Continued From page 11 temporary or permanent physical barrier. A (standard) window screen is not a wall." Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided.	{0 830}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 910}			

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{0 970}	Continued From page 12	{0 970}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	{01060}			

Minnesota Department of Health

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{01060}	Continued From page 13 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01060}			
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 14 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	{01470}			

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{01470}	Continued From page 15 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: Not reviewed during this survey.	{01470}			
{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 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	{01500}			

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{01500}	Continued From page 16 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			
{01540} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working	{01540}			

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{01540}	Continued From page 17 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01540}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	{01730}			

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{01730}	Continued From page 18 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}			
{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: Not reviewed during this survey.	{01880}			

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{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01940}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments	{01960}			

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{01960}	Continued From page 20 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01960}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 23, 2024

Licensee

Berkeley Heights Homes LLC

1509 Sugarloaf Trail

Brooklyn Park, MN 55444

RE: Project Number(s) SL36852015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

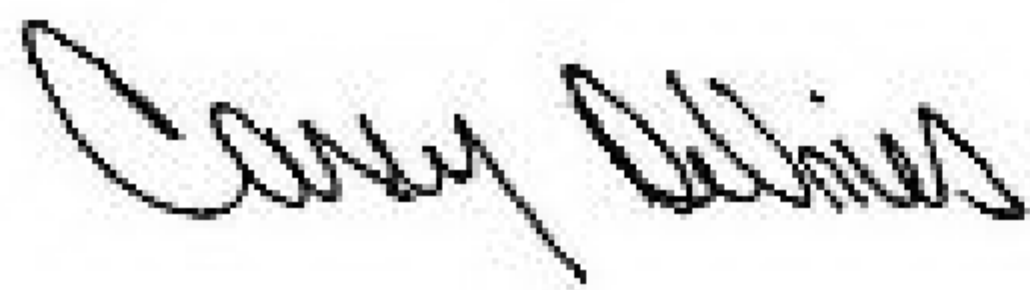
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444			
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36852015-0 On April 22, 2024, through April 26, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all of whom were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required and failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

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NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
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0 470	Continued From page 2 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: During the entrance conference on April 22, 2024, at 11:15 a.m., the surveyor requested the licensee's staffing schedule and staffing plan. Clinical nurse supervisor (CNS)-D stated, "We have the staff schedules posted in the app (electronic software application) they can access the staff schedule through the app. I honestly don't know the name of the app you can ask [licensed assisted living director (LALD)-C] when he comes, he is the one who handles the schedule." When asked about the staffing plan CNS-D stated, "That is [LALD] he does it buy himself, no I don't help with that, I have enough I my plate, when he comes you can ask him about it." On April 22, 2024, at 12:43 p.m., the surveyor received the licensee's undated Facility Staffing Plan that indicated it was completed by CNS-D. CNS-D stated "Did he (LALD-C) forget and put my name on it? This is [LALD-C's] job. I don't do this; he needs to put his name on it." CNS-D sent another employee to have LALD-C update the staffing plan. On April 22, 2024, at 12:45 p.m., LALD-C brought a new undated Facility Staffing Plan that indicated it was completed by LALD-C, and stated, "This one is the correct one, I am the one that does the	0 470			

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0 470	Continued From page 3 staffing plan. I typically re-evaluate it two to three times a year." On April 22, 2024, at 12:57 p.m., CNS-D stated, "I think I stopped doing that [staffing plan] last July. Then [LALD-C] took over, I just have too much on my plate." The licensee's Staffing policy, dated August 1, 2021, read, "1. The staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor." The policy also reads, "5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: -Home health aide work schedules for each home health aide showing all work shifts with days/hours worked -The home health aide's resident assignments or work location 6. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480			

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0 480	Continued From page 4 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 24, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510			

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0 510	Continued From page 5 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control. 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: Unlicensed Personnel (ULP)-E was hired July 13, 2022, to provide direct cares and services to residents. On April 22, 2024, at 12:20 p.m., the surveyor observed ULP-E empty R2's catheter bag. ULP-E washed their hands and donned gloves. ULP-E removed the drain tube from the drain holder, opened the clamp and emptied the contents of the catheter bag into another container by resting the drainage tube on the inside of the container. ULP-E clamped the drain tube and reinserted the drain tube into the drain tube holder. ULP-E did not clean the drain tube prior to opening the clamp or after closing the clamp. The Centers for Disease Control and Prevention's Guideline for Prevention of Catheter-Associated	0 510			

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0 510	Continued From page 6 Urinary Tract Infections dated June 6, 2019, reads, "Empty the collecting bag regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container." On April 22, 2024, at 12:25 p.m., ULP-E stated the staff do not clean the catheter when emptying the bag and stated, "No it is not the leg bag so if it was changed, then we clean, otherwise no we don't." On April 23, 2024, at 1:27 p.m., clinical nurse supervisor (CNS)-D stated, "They are expected to use an alcohol wipe on the tube that releases urine before they empty it and after they empty it, but it sounds like they didn't do that, so we will be re-educating." CNS-D was asked if the licensee had a policy on catheters and she replied "No, it is something we need to still put together." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650			

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0 650	Continued From page 7 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (clinical nurse supervisor (CNS)-D and unlicensed personnel (ULP)-B and ULP-E). 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: CNS-D CNS-D was hired August 8, 2022, to oversee and educate staff and provide direct cares and services to residents.	0 650			

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0 650	Continued From page 8 On April 22, 2024, at 11:15 a.m., the surveyor observed CNS-D working for the facility during the entrance conference. ULP-B ULP-B was hired May 9, 2022, to provide direct cares and services to residents. On April 22, 2024, at 11:51 a.m., the surveyor observed ULP-B administer medications to R3. ULP-E ULP-E was hired July 13, 2022, to provide direct cares and services to residents. On April 22, 2024, at 12:20 p.m., the surveyor observed ULP-E to empty R2's catheter bag. CNS-D, ULP-B, and ULP-E's employee records lacked an annual performance review for any years of employment with the licensee. On April 23, 2024, at 11:21 a.m., CNS-D stated, "Annual appraisals are something we still need to work on, nobody has them done yet." The licensee's Personnel Records policy dated August 1, 2021, indicated all employee records would be maintained by the licensee and would include performance reviews." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680			

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0 680	Continued From page 10 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's emergency disaster preparedness plan lacked evidence of the following required content: -develop and implement EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; -address the following whether evacuated or shelter in place for staff/residents: -food, water, medical supplies, pharmaceutical supplies; -alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may	0 680			

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0 680	Continued From page 11 include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On April 23, 2024, at 12:05 p.m., licensed assisted living director (LALD)-C acknowledged the licensee was missing the above-mentioned items and stated, "Is that all part of appendix Z? We don't have that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the residents, staff, and visitors.	0 800			

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0 800	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 24, 2024, at 12:15 p.m., survey staff toured the facility with licensed assisted living director (LALD)-C, and the following maintenance issues were observed. 1. It was observed that in resident room #1 the vinyl flooring was coming up. This resident room door had a hole in it and the bottom of the window frame had signs of deterioration due to lack of maintenance. 2. It was observed in resident room #2 bottom of the window frame had sign of deterioration due to lack of maintenance. 3. It was observed in resident room #4 that the window frame had signs of deterioration due to lack of maintenance. Closet doors and walls had several holes in them. The electric wall heater was dented in. Multiple stains on the carpet. The room had a musty smell. 4. It was observed that resident room #5 door had holes in it. The carpet was loose and heavily stained. 5. Closet door in basement hallway had a hole in it. 6. Downstairs hallway carpet was torn and coming loose. This could cause a tripping hazard. 7. Main level bathroom wall trim was coming off. 8. Vent cover underneath kitchen sink was	0 800			

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0 800	Continued From page 13 missing. 9. The vinyl flooring on the steps going up to the main level was coming up. 10. Laundry room window frame had sign of deterioration due to lack of maintenance. 11. Front concrete steps going into the front entrance were not steady and moved when stepped on them. 12. The wooden deck and patio in the back yard had signs of deterioration due to lack of maintenance. 13. Several chairs in the garage and on the deck showed signs of cigarette burns. 14. The sheet rock under the garage door entrance to the house was missing sheet rock. 15. Crack in the header wall between the kitchen and living room. 16. Drawer in kitchen cabinet come unattached from the draw slides. 17. House siding under the front door was coming off. 18. Front entrance storm door was missing its hardware and not working properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810			

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0 810	Continued From page 14 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to	0 810			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
(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 15 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted via email on April 25, 2024, at 1:30 p.m. with licensed assisted living director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan uses the RACE acronym which is very basic and does not show the employees actions in the event of a fire or similar emergency. Record review of the available documentation indicated that the evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan uses the RACE acronym which is very basic and does not show the residents actions in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820			

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0 820	Continued From page 16 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee had locking arrangements on the outside of resident room #4 this did not constitute a distinct hazard to life but had the potential to directly affect all residents and staff. 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). On April 24, 2024, at 12:45 p.m. survey staff toured the facility with the licensed assisted living director (LALD)-C. It was observed that resident room # 4 had a latch style door lock on the outside of the resident's door. This was on the outside which would allow anyone in the facility to lock the door, trapping another person inside this room. Survey staff explained to LALD-C that the latch style door locks on the hallway side	0 820			

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0 820	Continued From page 17 constituted an obstruction of egress and resident safety. LALD-C verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of four residents (R3, R4, and R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 830			

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0 830	Continued From page 18 On April 22, 2023, at 10:05 a.m., the surveyor observed R4 standing in the attached garage smoking a cigarette. R3 R3 admitted to the facility on April 1, 2023. R3's diagnoses included diabetes, anxiety, depression, and PTSD. R3's Service Plan dated April 15, 2023, indicated R3 received assistance with dressing, oral hygiene, hair care, grooming, and bathing, blood sugar checks three times a day, medication reminders, medication administration, meal preparation, weekly housekeeping, weekly linen change, and hourly safety checks. R3's last clinical update assessment dated April 2, 2024, indicated under safe smoking assessment, that R3 smoked in the designated smoking areas. R4 R4 admitted to the facility on June 4, 2023. R4's diagnoses included diabetes and schizoaffective disorder. R4's Service Plan dated September 18, 2023, indicated R4 received assistance with grooming, assistance with bathing, medication reminders, medication administration, meal preparation, weekly housekeeping, weekly linen change, and hourly safety checks. R4's last clinical update assessment dated March 15, 2024, indicated under safe smoking assessment, that R4 smoked in the designated smoking areas.	0 830			

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0 830	Continued From page 19 R5 R5 admitted to the facility on January 31, 2024. R5's diagnoses included diabetes, PTSD, and bipolar II disorder. R5's Service Plan dated January 31, 2024, indicated R5 received medication reminders, medication administration, meal preparation, weekly housekeeping, weekly linen change, and hourly safety checks. R5's 14-day assessment dated February 14, 2024, indicated under safe smoking assessment, that R5 understands and can locate designated smoking areas as well as smoked in the designated smoking areas. During observation on April 23, 2024, at 8:30 a.m., the surveyor observed ULP-B cleaning up cigarette butts from the floor of the attached garage. The garage contained six wood and fabric covered chairs, two couches, a mattress, and several containers of bagged garbage, as well as miscellaneous furniture and stored items. Several of the wooden and fabric chairs had burn marks on them, and there were multiple cigarette butts located on the ground directly outside the front and back of the garage doors. The layout of the facility was a split-level residential home with a connecting garage. There were no fire extinguishers located in the garage. On April 23, 2024, at 8:30 a.m., unlicensed personnel (ULP)-B stated, "The garage is the preferred area they like to smoke, and it is part of our job each shift to clean up the area." On April 23, 2024, at 9:15 a.m., licensed assisted	0 830			

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0 830	Continued From page 20 living director (LALD)-C stated, "The residents all smoke in the garage and on deck. Those are the only areas they smoke, there is no smoking allowed inside. There is one resident that I've never seen smoke [R2] but all the rest do. Nobody complains of the smell of smoke, we leave the garage door open to air it out and they all smoke by the front area (closest to the garage door) so nothing in the garage is at risk for fire." The licensee's Residents' Smoking in designated areas policy, dated August 1, 2021, read, "Smoking shall be only permissible outside of the facility like in the backyard and the garage areas." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. A (standard) window screen is not a wall." Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.	0 830			

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0 830	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee began providing services under their	0 910			

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0 910	Continued From page 22 assisted living facility license on August 1, 2021. R2 was admitted June 24, 2023, and began receiving assisted living services. R2's record included a Residency Agreement signed by R2 on June 24, 2023. R2's written contract lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On April 26, 2024, at 8:10 a.m., licensed assisted living director (LALD)-C stated, "That (HFID) is something that is different for each facility, and we have four and we use the same service plan and contract for each place (facility). We could get that created so the nurse can add it (HFID) manually. That is something we can get fixed asap." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

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0 970	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted June 24, 2023, and began receiving assisted living services. R2's record included a Residency Agreement signed by R2 on June 24, 2023, which read, "INDEMNIFICATION Resident will indemnify and hold harmless landlord, and agents from and against any and all claims, actions, damages, and the liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of the Landlord's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." As well as "LIABILITY Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Landlord's premises unless such injury, death or property damage occurs as the	0 970			

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0 970	Continued From page 24 result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Landlord is also not liable for any injury, death or damage occurring as a result of Resident's receipts of health-related, supportive, or other services from third party providers." On April 23, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-D acknowledged that all of the resident contracts had the indemnification and liability language in them and stated, ""We use the same contract for all of our residents for all four facilities, I will need to get [LALD] so he can learn what is wrong with the contract and get it fixed." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060			

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01060	Continued From page 25 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R2).	01060			

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01060	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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted June 24, 2023, and began receiving assisted living services. R2's Signed Service Plan dated February 1, 2024, indicated R2 received services to include assistance with dressing, self-feeding TPN, assistance with grooming, toileting (ileostomy emptying), bathing, standby assist, medication reminders, medication administration, treatments and exercises, personal laundry, housekeeping and linen changes, behavior monitoring, and safety checks. R2's nurse progress notes indicated R2 was hospitalized from March 22, 2024, through March 29, 2024. On April 23, 2024, at 10:43 a.m., clinical nurse supervisor (CNS)-D stated, " No we don't have it (emergency relocation form), I did not even know that we were supposed to do that." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01470	Continued From page 27	01470			
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470			

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01470	Continued From page 28 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 interview and record review, the licensee failed to ensure employee orientation included all required content for two of three employees (unlicensed personnel (ULP)-B and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B	01470			

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NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
(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 29 ULP-B was hired May 9, 2022, to provide direct cares and services to residents. ULP-E ULP-E was hired July 13, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee records lacked orientation to assisted living regulations to include the following: -principles of person-centered planning/service delivery. On April 23, 2024, at 11:56 a.m., clinical nurse supervisor (CNS)-D stated, "I'm not sure why they don't have that course, maybe they have not completed their educare (a computerized training software), I have it on mine, but they don't have it. But let me call [LALD] because he is the one who assigns it." On April 23, 2024, at 11:58 a.m., licensed assisted living director (LALD)-C stated, "Most of those (courses) are reassigned each year and we are in the process of getting that reassigned for everyone." The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing services to residents would be trained by the CNS or delegate and the training would include principles of person-centered planning/service delivery. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			

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01500	Continued From page 30	01500			
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 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.	01500			

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01500	Continued From page 31 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-B and ULP-E) 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:	01500			

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01500	Continued From page 32 ULP-B ULP-B was hired May 9, 2022, to provide direct cares and services to residents. ULP-E ULP-E was hired July 13, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee records lacked evidence annual training had been completed as required in the following areas: -effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of provider's policies and procedures; and -principles of person-centered planning/service delivery. On April 23, 2024, at 11:58 a.m., licensed assisted living director (LALD)-C stated, "Most of those (courses) are reassigned each year and we are in the process of getting that reassigned for everyone." The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing services to residents would complete eight hours of education for every twelve months of employment, and would cover the above-mentioned topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01540	Continued From page 33	01540			
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B and ULP-E) completed the required amount of dementia care training in the required time frame. 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).	01540			

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01540	Continued From page 34 The findings include: ULP-B ULP-B was hired May 9, 2022, to provide direct cares and services to residents. ULP-E ULP-E was hired July 13, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee file contained initial dementia Educare training (an electronic training software) but lacked any annual training hours on dementia. On April 23, 2024, at 11:58 a.m., licensed assisted living director (LALD)-C stated, "Most of those (courses) are reassigned each year and we are in the process of getting that reassigned for everyone." The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing services to residents would complete eight hours of education for every twelve months of employment, and would cover the above-mentioned topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a	01730			

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01730	Continued From page 35 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	01730			

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01730	Continued From page 36 Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 admitted to the facility on April 1, 2023. R3's diagnoses included diabetes, anxiety, depression, and PTSD. R3's Service Plan dated April 15, 2023, indicated R3 received assistance with dressing, oral hygiene, hair care, grooming, and bathing, blood sugar checks three times a day, medication reminders, medication administration, meal preparation, weekly housekeeping, weekly linen change, and hourly safety checks. R3's Medication Administration Record, dated April 1, 2024, through April 31, 2024, indicated R3 received medication administration from April 1, 2024, through April 22, 2024. R3's Medication Administration Record, dated April 1, 2024, through April 31, 2024, indicated R3 received Novolog flexpen, inject 20 units subcutaneously twice a day before breakfast and	01730			

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01730	Continued From page 37 lunch, and 25 units subcutaneously before dinner, and a Soliqua injection, 36 units subcutaneously before dinner. On April 22, 2024, at 11:51 a.m., the surveyor observed ULP-B provide blood glucose monitoring for R3 and assist R3 with insulin administration. R3's resident records lacked an individualized medication management record to include specific resident instructions relating to the medication administration. On April 23, 2024, at 11:37 a.m., clinical nurse supervisor (CNS)-D stated, "The staff should update me when the blood sugar is high or low and they are trained to do that, but I don't have instructions anywhere for the residents of when to hold medications or anything specific like that. They should know to call me and then I guess I would tell them what needs to be done." The licensee's Medication Administration policy, dated August 1, 2021, indicated the written medication management plan would include, "written instructions for the home health aide in the proper methods to administer medications with respect to each resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

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01880	Continued From page 38 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 for three of three residents (R2, R3, and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, at 1:15 p.m., the surveyor observed a mini refrigerator located in a shared living room, which contained medications for three residents. The facility had a Refrigerator and Freezer Temperature Log dated April 1-31, 2024, that indicated the mini refrigerator temperature was 30 degrees on April 13, 22, and 23, and the refrigerator temperature was 50 degrees on April 14, 2024. The mini refrigerator contained one bottle with an unknown amount of midodrine hydrochloric acid (hcl) 1mg/ml (used to treat low blood pressure), four Aimovig 70mg/ml (migraine medication), and one bottle with an unknown amount of bupropion hcl 20mg/ml (antidepressant) for R2, five Novolog flex pens, and one Soliqua 100/33 insulin pens for R3, and two Ozempic 2mg/3ml pens (weight loss) for R5.	01880			

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01880	Continued From page 39 R2 R2's Signed Service Plan dated February 1, 2024, indicated R2's services included medication reminders and medication administration. R3 R3's Service Plan dated April 15, 2023, indicated R3's services included medication reminders and medication administration. R5 R5's Service Plan dated January 31, 2024, indicated R5's services included medication reminders and medication administration. The manufacturer's guidelines for the use of Aimovig 70mg/ml located on the prescription packaging, indicated unused pens should be refrigerated at 36 degrees to 46 degrees Fahrenheit until first use. The manufacturer's guidelines for the use of bupropion hcl, dated April 23, 2024, indicated the medication should be stored at room temperature between 68 degrees to 77 degrees Fahrenheit. The manufacturer's guidelines for the use of Novolog insulin pen located on the prescription packaging, indicated unused pens should be refrigerated at 36 degrees to 46 degrees Fahrenheit until first use. The manufacturer's guidelines for the use of Soliqua 100/33 insulin pens located on the prescription packaging, indicated unused pens should be refrigerated at 36 degrees to 46 degrees Fahrenheit until first use.	01880			

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01880	Continued From page 40 On April 23, 2024, at 1:38 p.m., clinical nurse supervisor (CNS)-D stated, "Nobody told me the fridge temps were off, so I never did anything about it, they are supposed to contact me right away if the fridge temps are off." The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications would be stored according to manufacturer's guidelines and the medication refrigerator would be maintained between 35 degrees and 40 degrees. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be 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	01940			

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01940	Continued From page 41 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include all treatments or therapies ordered for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted June 24, 2023, and began receiving assisted living services. R2's diagnoses included anorexia nervosa, gastroesophageal reflux disorder, history of blood clots, PTSD, malnutrition, hypotension, and major	01940			

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01940	Continued From page 42 depressive disorder. R2's Signed Service Plan dated February 1, 2024, indicated R2 received services to include assistance with dressing, self-feeding TPN, assistance with grooming, toileting (ileostomy emptying), bathing, standby assist, medication reminders, medication administration, treatments and exercises, personal laundry, housekeeping and linen changes, behavior monitoring and safety checks. R2's signed doctor's orders dated February 6, 2024, read, "Compression stockings (knee-high) 12 hrs(hours)/day". R2's Individualized Treatment or Therapy Management Plan dated April 1, 2024, included parts of the individualized treatment management plan, though lacked services relating to compression stockings. On April 23, 2024, at 10:15 a.m., clinical nurse supervisor (CNS)-D stated, "I must not have put it on there. I missed that, yes she gets assistance with her compression stockings, but I forgot to update the service plan and transfer the order for those to the April MAR (medication administration record)." The licensee's Treatment and Therapy Management policy, dated August 1, 2021, read, "The RN (registered nurse) or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of services to be provided b. Procedures for documenting treatments or therapies	01940			

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01940	Continued From page 43 c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed professional when a problem arises related to the treatment or therapy services." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of two residents (R2) receiving treatments. 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	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
(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
01960	Continued From page 44 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: R2 was admitted June 24, 2023, and began receiving assisted living services. R2's diagnoses included anorexia nervosa, gastroesophageal reflux disorder, history of blood clots, PTSD, malnutrition, hypotension, and major depressive disorder. R2's Signed Service Plan dated February 1, 2024, indicated R2 received services to include assistance with dressing, self-feeding TPN, assistance with grooming, toileting (ileostomy emptying), bathing, standby assist, medication reminders, medication administration, treatments and exercises, personal laundry, housekeeping and linen changes, behavior monitoring and safety checks. R2's signed doctor's orders dated February 6, 2024, read, "Compression stockings (knee-high) 12 hrs(hours)/day". R2's Medication Administration Record, dated April 1, 2024, through April 31, 2024, which was used by the licensee for documenting medications and treatments, lacked documentation of any use of compression stockings. On April 23, 2024, at 10:15 a.m., clinical nurse supervisor (CNS)-D stated, "I must not have put it	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
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01960	Continued From page 45 on there. I missed that, yes she gets assistance with her compression stockings, but I forgot to update the service plan and transfer the order for those to the April MAR (medication administration record)." The licensee's Treatment and Therapy Management policy, dated August 1, 2021, read, "Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee posted signage that used language which limited the rights of all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER BERKELEY HEIGHTS HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SUGARLOAF TRAIL BROOKLYN PARK, MN 55444		
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02290	Continued From page 46 or has the potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, at 9:15 a.m., during the facility tour, the surveyor observed a note posted in the common dining room that read, "[Licensee's], visiting rules and time. Visiting hours: 9:00 AM-9:30 PM Visitor is not allowed to sleep over. For a visitor to sleep over, there should be a 24 hour notice. We only allow visitor to sleep over twice a week. Management" On April 23, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-D stated, "Well, they are allowed visitors, they just have to ask permission first if it is outside of visiting hours. We need to know why they want to have someone here, and they need to get it cleared. We can't just have visitors showing up, they need to ask first, then we will try to make it work if it is a necessary visit." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

Type: Full
Date: 04/24/24
Time: 09:14:51
Report: 1018241067

Food and Beverage Establishment Inspection Report

Page 1

Location:

Berkeley Heights Homes LLC
1509 Sugarloaf Trail
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0042572
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR.
DISCUSSED MOVING EGGS TO THE BOTTOM OF THE FRIDGE TO PREVENT CROSS
CONTAMINATION.

Comply By: 04/24/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

ESTABLISHMENT IS NOT CURRENTLY DOING ALL SAME DAY SERVICE FOR RESIDENTS.
DISCUSSED WITH STAFF THAT ALL HEATED AND PREPARED FOODS MUST BE SAME DAY
SERVICE ONLY.

Comply By: 04/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LARGE HOLE UNDERNEATH SINK OBSERVED. DRAWER ON KITCHEN ISLAND OBSERVED TO
BE BROKEN. COMPLY WITH RULE.

Comply By: 07/26/24

Type: Full
Date: 04/24/24
Time: 09:14:51
Report: 1018241067
Berkeley Heights Homes LLC

Food and Beverage Establishment Inspection Report

Page 2

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

HEAVY DEBRIS BUILD UP OBSERVED ON FLOOR ESPECIALLY AROUND CORNERS AND BASES OF EQUIPMENT. COMPLY WITH RULE.

Comply By: 05/10/24

Food and Equipment Temperatures

Process/Item: Cold Holding/ DELI MEAT

Temperature: 41 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: No

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

VIEWED ILLNESS LOG

EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

FLOORS, WALLS AND CEILINGS OBSERVED TO BE IN GOOD CONDITION ASIDE FROM DEBRIS BUILD UP.

2 BASIN SINK AVAILABLE FOR HAND WASHING AND FOOD PREP.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

DISCUSSED PEST CONTROL.

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

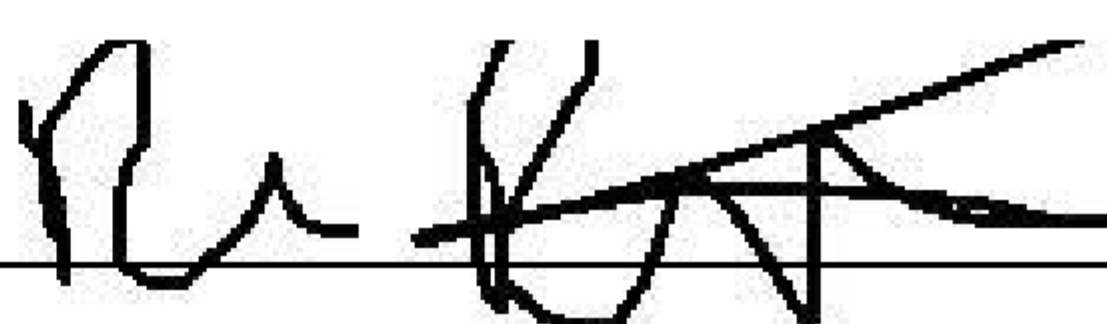
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241067 of 04/24/24.

Certified Food Protection Manager: MICHEAL GBUTU NORNIC

Certification Number: FM111585 Expires: 03/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
TESA BROWN

Signed:  _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us