Electronically Delivered

January 2, 2024

Licensee
Bethany Assisted Living
117 2nd Street Northeast
Fosston, MN 56542

RE: Project Number(s) SL32029015

Dear Licensee:

On November 16, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 30, 2023, 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,

Tim Hanna, Interim Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2023

Licensee
Bethany Assisted Living
117 2nd Street Northeast
Fosston, MN 56542

RE: Project Number(s) SL32029015

Dear Licensee:

On September 25, 2023, 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 August 30, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 30, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 30, 2023, found not corrected at the time of the September 25, 2023, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on September 25, 2023 (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.

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.

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 the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

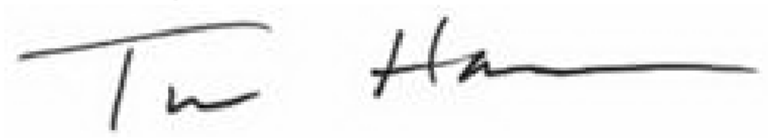
Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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,



Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32029	A. BUILDING: _____ B. WING _____	R 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING	117 2ND STREET NE FOSSTON, MN 56542

(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: Project SL32029015-1 On September 25, 2023, the Minnesota Department of Health conducted a desk audit at the above provider to follow-up on orders issued pursuant to a survey completed on August 29, 2023. At the time of the survey, there were residents: 28 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BETHANY ASSISTED LIVING	117 2ND STREET NE FOSSTON, MN 56542

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{0 000}	Continued From page 1	{0 000}	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required	{0 485}		
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	{0 630}		

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{0 630}	Continued From page 2 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No Further action required	{0 630}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	{0 730}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 730}	Continued From page 3 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required	{0 730}		
{0 800} SS=D	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.	{0 800}		

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{0 800}	Continued From page 4 This MN Requirement is not met as evidenced by: No further action required	{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 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	{0 810}		

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{0 810}	Continued From page 5 drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{0 820} SS=B	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 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 interview and record review, the licensee failed to provide egress windows in resident rooms that meet the minimum size requirements and that do not constitute a distinct hazard. This had the potential to directly affect a portion of residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 6 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: On September 25, 2023, between the hours of 9:48 a.m. and 3:18 p.m., survey staff did a desk follow-up per email with Licensed Assisted Living Director (LALD-A). During the desk follow-up, survey staff inquired about the egress windows in resident rooms (112A, 101, 102, 104, 105, 106, 107, 108, 109) not meeting the minimum size requirements from the survey that was conducted on August 29, 2023. LALD-A stated, they are still waiting for the windows to come in and that they ordered them on Wednesday August 30, 2023, and that it could take up to 4-6 weeks for delivery. A record review of the fire watch logs indicated that the licensee has continued fire watch protocols every 30 minutes of each day since executing this as the plan of correction from the immediate order from the previous survey. LALD-A emailed these logs which confirmed that the staff was executing all required fire watch protocols during each shift. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 820}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 940}	Continued From page 7 program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 970}	Continued From page 8	{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: No further action required	{0 970}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	{01620}		

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{01620}	Continued From page 9 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required	{01620}		
{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: No further action required	{01880}		

Electronically Delivered

September 15, 2023

Licensee
Bethany Assisted Living
117 2nd Street Northeast
Fosston, MN 56542

RE: Project Number(s) SL32029015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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.

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 the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32029	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING	117 2ND STREET NE FOSSTON, MN 56542

(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(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: SL32020015-0 On August 28, 2023, through August 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 27 active residents; 27 receiving services under the Assisted Living license. The immediate correction order(s) tag identification 0820, identified on August 29, 2023 has had the immediacy lifted as of August 29, 2023.	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.	
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living agreement did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 28, 2023, at 9:30 a.m., surveyor	0 485		

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0 485	Continued From page 2 requested a copy of the licensee's contract/service agreement. The Resident Agreement, page 17 of 24, titled Meal Plan, indicated the licensee offered three meals (breakfast, lunch and supper) and two snacks daily. In addition, the agreement indicated these meals were included in the base rate and were not able to be deducted if the resident doid not eat a specific meal. Additionally, page 15, titled Rates for Services, indicated service category charges for the following: breakfast $3.67 per day; lunch $4.57 per day, supper $4.57 per day, and snack $0.90 per day. On August 30, 2023, at 11:15 a.m., licensed assisted living director (LALD)-A stated the meal plan was part of the base price and this was the same agreement used for all the residents. He was not aware the licensee could not require a resident to include and pay for their meals as part of the resident agreement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 3 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for two of two residents (R1, 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) 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: R1 R1's diagnoses included diabetes (low blood sugar), right eye palsy (problems with eye movement), and chronic kidney disease. R1's service plan dated June 27, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, wound care, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry. On August 29, 2023, at 7:57 a.m., surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications.	0 630		

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0 630	Continued From page 4 R1's Individual Abuse Prevention Plan (IAPP) dated June 6, 2023, identified areas of vulnerability with interventions and a review of the resident's susceptibility to abuse other individuals, including other vulnerable adults and self-harm. R1's IAPP did not include a review of the resident's susceptibility to abuse by another individual, including other vulnerable adults. R2 R2's diagnoses included diabetes (low blood sugar), hypertension (high blood pressure), and bipolar disorder (episodes of mood swings). R2's service plan dated August 28, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry. On August 29, 2023, at 8:15 a.m., surveyor observed ULP-C administer R2's scheduled morning medications and check blood sugar. R2's IAPP dated March 1, 2023, identified areas of vulnerability with interventions and a review of the resident's susceptibility to abuse other individuals, including other vulnerable adults and self-harm. R2's IAPP did not include a review of the resident's susceptibility to abuse by another individual, including other vulnerable adults. On August 30, 2023, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's IAPP's did not include a review of the resident's susceptibility to abuse by another individual, including other vulnerable adults. Additionally, she stated the IAPP format was currently used for all	0 630		

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0 630	Continued From page 5 the residents. She was not aware the resident's susceptibility to abuse by another individual needed to be included in the IAPP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 6 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 Discharge Resident Roster dated August 28, 2023, indicated R3 was admitted to the facility and started to receive services on April	0 730		

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0 730	Continued From page 7 26, 2016, and was discharged on March 7, 2023. R3's diagnoses included cirrhosis of the liver (scarring and liver failure), hypertension (high blood pressure), thiamine (vitamin B1) deficiency. R3's record contained the following progress note: -March 7, 2023, at 2:31 p.m., progress note by clinical nurse supervisor (CNS)-B noted "[name] hospital has transferred R3 to [name] nursing home in [name] due to elevated need of care following a left hip repair. Call placed to mother [name], case manager [name] and administrator notified." R3's record included a disposition of medications and emergency relocation notice, however lacked a discharge summary. On August 28, 2023, at 2:42 p.m., CNS-B and licensed assisted living director (LALD)-A stated a discharge summary for R3 was not completed. CNS-B stated she had not been completing a discharge summary when a resident is discharged. The licensee's Contract Termination policy dated August 30, 2022, indicated at the time of discharge, [name] assisted living will provide the resident, and, with a resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes: -A summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent labs, radiology, and consultation results. -A final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline	0 730		

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0 730	Continued From page 8 and current mental, behavioral, and functional status. -A reconciliation of predischarge medications with the resident's post discharge prescribed and over the counter medications. -A post discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to the new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that has been made for the resident' s follow-up care, and any post-discharge medical and nonmedical services the resident will need. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9. Resident discharge summary. At the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 800 SS=D	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.	0 800		

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0 800	Continued From page 9 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On 08/29/2023, from approximately 10:30 a.m. to 11:30 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A. During the facility tour, survey staff observed and verified the following maintenance issues: It was observed that the ceiling tile in resident rooms #107 and #104 closet had yellow stains from the ceiling leaking. It was observed that the bathroom fan in the lower south wing was not working. It was observed that resident room #102-bathroom ceiling tile had yellow stains from leakage. It was observed that the walls and ceiling sheet	0 800		

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0 800	Continued From page 10 rock was unfinished in the corridor from the new north addition to the sunrise addition and part of the sunrise addition ceiling. It was also observed that emergency exit doors on the south wing and penthouse were sliding glass doors which removes a safe means of egress during a fire or similar emergency. These emergency exit doors were identified in the facility's evacuation plan. LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 11 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. The facility plan indicated to use RACE acronym but did not provide complete actions for employees and residents to take in the event of a fire or similar emergency. 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 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:	0 810		

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0 810	Continued From page 12 A record review and interview were conducted on August 29, 2023, at approximately 1:30 p.m. with Licensed Assisted Living Director (LALD). 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 licensee did not have employee and resident actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review did not show specific employee actions to be taken in the event of a fire or similar emergency. Record review did not show specific fire protection procedures necessary for residents. Record review did not have complete information that shows 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. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 13 (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 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 failed to ensure the minimum size egress window openings for occupied and unoccupied resident bedrooms. This affected nine of the occupied resident bedrooms and one unoccupied bedrooms. This had the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, between the hours of 10:30 a.m. and 11:30 a.m., survey staff toured the home	0 820	This immediate correction order identified on August 29, 2023, has had the immediacy lifted as of August 29, 2023 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32029	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING	117 2ND STREET NE FOSSTON, MN 56542

(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
0 820	Continued From page 14 with Licensed Assisted Living Director (LALD)-A. At approximately 10:45 a.m., survey staff measured the windows in occupied bedrooms Penthouse #112A-(14.5Wx87H), South #101-(20.5Wx19.5H), South #102-(28Wx13.5H), South #104-(16Wx68H), South #105-(16Wx68H), South #106-(11Wx33H), South #108-(11Wx33H), South #109-(35.5Wx14.5H) and unoccupied bedrooms #107-(35.5Wx14.5H). It was explained to the LALD-A that the window in these bedroom's did not meet the minimum size egress window openings required for safe egress. At least one window in each resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet) required for egress. LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of	0 940		

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	32029	A. BUILDING: _____ B. WING _____	08/30/2023

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BETHANY ASSISTED LIVING	117 2ND STREET NE FOSSTON, MN 56542

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0 940	Continued From page 15 people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living agreement included all required content for three of three residents (R1, R2). This had the potential to affect all 27 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	0 940		

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0 940	Continued From page 16 the residents). The findings include: R1 R1's diagnoses included diabetes (low blood sugar), right eye palsy (problems with eye movement), and chronic kidney disease. R1's service plan dated June 27, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, wound care, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry. R2 R2's diagnoses included diabetes (low blood sugar), hypertension (high blood pressure), and bipolar disorder (episodes of mood swings). R2's service plan dated August 28, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry. R1 and R2's resident agreement dated July 1, 2023, and June 30, 2023, respectively, did not include the following information: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time, and if so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	0 940		

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0 940	Continued From page 17 time that private payment is required; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On August 30, 2023, at 11:38 a.m., licensed assisted living director (LALD)-A stated the agreement did not include all the required contents identified above and the same agreement was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
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: Based on interview and record review, the licensee failed to ensure the residential lease did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 970	Continued From page 18 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 the potential to affect a large portion or all the residents). The findings include: On August 28, 2023, at 9:30 a.m., during the entrance conference, the surveyor asked for a copy of the facility's assisted living contract. The residential lease provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. -Page 3, section 15. Damage or injury to tenant or tenants property in residential lease agreement indicated the landlord is not responsible for any injury or damage that was not caused by a willful or negligent act or failure to act of landlord. On August 30, 2023, at 11:15 a.m., licensed assisted living director (LALD)-A stated the facility provided the same residential lease to all residents. LALD-A reviewed section 15 of the lease, and stated he was not aware waivers of liability were prohibited in the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01620	Continued From page 19	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure a registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for two of two residents (R1, 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	01620		

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01620	Continued From page 20 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 the residents). The findings include: R1 R1's diagnoses included diabetes (low blood sugar), right eye palsy (problems with eye movement), and chronic kidney disease. R1's service plan dated June 27, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, wound care, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry. R1's current 90 day/Change in Condition Monitoring and Behavior Reassessment dated August 11, 2023, included a review of services including, dressing, hygiene, bathing, continence, medication administration, laundry, housekeeping and comments regarding changes in medications and past appointments. R2 R2's diagnoses included diabetes (low blood sugar), hypertension (high blood pressure), and bipolar disorder (episodes of mood swings). R2's service plan dated August 28, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, assistance with dressing, grooming, and bathing, behavior monitoring, housekeeping, and laundry.	01620		

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01620	Continued From page 21 R2's current 90 day/Change in Condition Monitoring and Behavior Reassessment dated August 11, 2023, included a review of services including, dressing, hygiene, bathing, continence, medication administration, laundry, housekeeping and comments regarding changes in medications and past appointments. On August 29, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the 90-day/Change in Condition Visit Monitoring and Reassessment document was used for all residents and did not include all content required for the uniform assessment tool in Minnesota Rules Chapter 4659.0150, Subp. 2. On August 29, 2023, at 3:10 p.m., licensed assisted living director (LALD)-A stated he knew the 90-day assessment was missing some components. Additionally, he stated he created the assessments in the electronic software system, and he needed to add more components. The licensee's Assessments, Reviews and Monitoring policy dated August 30, 2022, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated and signed by the registered nurse who conducted the assessment. Minnesota Rules - Assisted Living Facilities Chapter 4659.0150 Uniform Assessment Tool, subpart 2, indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in	01620		

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01620	Continued From page 22 this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription and over the counter medications were securely locked in a manner that would permit only authorized personnel to have access in a basement conference room where medications were stored. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 28, 2023, at 10:54 a.m., during entrance tour the surveyor observed several	01880		

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01880	Continued From page 23 unopened over the counter medications on a shelf, and an unsecured refrigerator containing insulins and Tuberculin solution in the basement conference room. There were several rooms located in the basement by the conference room, which included, but not limited to, licensed assisted living director office, clinical nurse supervisor office, food protection manager office, staff break room, and restrooms. The conference room had four (4) entry doors, two (2) unsecured doors from the hallway into conference room, and a keypad door to enter the licensed assisted living director (LALD) and clinical nurse supervisor (CNS) offices. On August 28, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated the extra over the counter medications and unopened insulins were kept in the refrigerator in the basement conference room. She stated there was a code staff use on the upstairs door to enter to have access to these medications. On August 29, 2023, at 7:00 a.m., upon arrival, surveyor observed the 2 main entry doors unsecured to the basement conference room with easy access to the over-the-counter medications and unsecured medication refrigerator. On August 30, 2023, at 11:07 a.m., LALD-A and CNS-B stated they had thought the key pad lock at the top of the stairs would keep the medications secured, however, stated all staff has access to the basement conference room making the medications easily accessable. The licensee's Medication Storage policy dated July 9, 2021, indicated medications managed outside of a resident's private "living space" must be in securely locked and substantially	01880		

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01880	Continued From page 24 constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164
218-332-5150

Type: Full
Date: *08/28/23*
Time: 12:39:05
Report: 1042231054

Food and Beverage Establishment Inspection Report

Location:
Bethany Assisted Living
117 Second Street NE
Fosston, MN56542
Polk County, 60

Establishment Info:
ID #: 0002567
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Bethany Board and Lodge, Inc.

Phone #: 2184351044
ID #: 22617

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 174.2 Degrees Fahrenheit
Location: Dishwasher in Kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37.8 Degrees Fahrenheit - Location: Upright Cooler in Main Kitchen- Cherry Tomatoes
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36.1 Degrees Fahrenheit - Location: Upright Cooler in Backup area- Packaged Coffee pre-mixed.
Violation Issued: No

Process/Item: Steam Table
Temperature: 181.9 Degrees Fahrenheit - Location: Steam table in Main Kitchen
Violation Issued: No

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

No Orders:
- Floors, walls, and ceilings in kitchen and storage area are secure and smooth with light fixtures covered.
- Sanitizer used for any red sanitize buckets is chlorine liquid bleach, not scented or low-splash
- All food is delivered daily for resident consumption and is pre-made or cooked according to CFPM (ex. egg patties for breakfast items)
- All food products and storage are dry, clean, and 6+ in. above ground level and identified easily.

Type: Full
Date: *08/28/23*
Time: 12:39:05
Report: 1042231054
Bethany Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 1042231054 of 08/28/23.

Certified Food Protection Manager: Julie A Eia

Certification Number: FM109133 Expires: 01/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us

Report #: 1042231054

Food Establishment Inspection Report

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164

No. of RF/PHI Categories Out	0	Date	08/28/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:39:05
Legal Authority MN Rules Chapter 4626		Time Out	

Bethany Assisted Living	Address: 117 Second Street NE	City/State: Fosston, MN	Zip Code: 56542	Telephone: 2184351044
License/Permit #: 0002567	Permit Holder: Bethany Board and Lodge, Inc.	Purpose of Inspection: Full	Est Type:	Risk Category: L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 08/28/23

Inspector (Signature)