Electronically Delivered

February 22, 2023

Licensee
Beehive Homes
14282 Business Center Drive Northwest
Elk River, MN 55330

RE: Project Number(s) SL33602015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email 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

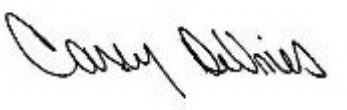
REQUESTING A HEARING

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

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

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

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33602	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES	14282 BUSINESS CENTER DRIVE NW ELK RIVER, MN 55330

(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: SL33602015 On January 30, 2023, through January 31, 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 22 active residents, all receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 31, 2023, at 8:00 a.m., the evaluator observed unlicensed personnel (ULP)-F administer medications to R7. ULP-F did not perform hand hygiene either before or after the	0 510		

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0 510	Continued From page 2 medication administration. On January 31, 2023, at 8:15 a.m., the evaluator observed ULP-E enter R3's apartment to provide morning cares without performing hand hygiene. ULP-E assisted with transfer out of bed and ambulation to the bathroom. ULP-E donned gloves, without performing hand hygiene, before assisting R3 with pulling incontinent brief down. Without performing hand hygiene or changing gloves ULP-E then proceeded to apply compression stockings, assist with dressing, washed his face, pulled his incontinent brief, and pants up and assisted with transfer off toilet. ULP-E doffed gloves and failed to perform hand hygiene. ULP-E then escorted resident to the dining room for breakfast. ULP-E failed to perform hand hygiene after all assistance with resident was completed. On January 31, 2023, at 8:20 a.m., the evaluator observed ULP-F administer medication to R8. ULP-F did not perform hand hygiene either before or after the medication administration. On January 31, 2023, at 8:35 a.m., the evaluator ULP-E enter R5's apartment to provide morning cares without performing hand hygiene. ULP-E assisted R5 with dressing and grooming and then escorted R5 to the dining room. ULP-E failed to perform hand hygiene after all assistance with resident was completed. On January 31, 2023, at 8:40 a.m., the evaluator observed ULP-F administer medications to R4. ULP-F did not perform hand hygiene either before or after the medication administration. On January 31, 2023, at 8:42 a.m., the evaluator observed ULP-F administer medications to R3.	0 510		

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0 510	Continued From page 3 ULP-F did not perform hand hygiene either before or after the medication administration. On January 31, 2023, at 8:45 a.m., the evaluator observed ULP-F administer medications to R6. ULP-F did not perform hand hygiene either before or after administering the medication. ULP-F donned gloves to administer R6's eye drops but failed to perform hand hygiene before donning the gloves and after doffing the gloves. On January 31, 2023, at 8:50 a.m., ULP-F stated she usually performs hand hygiene every two medication passes. On January 31, 2023, at 2:30 p.m., licensed assisted living director (LALD)-A stated staff were trained to wash or sanitize their hands before and after assisting with each resident's medication administration, after toileting assistance, between resident cares, before and after using gloves and anytime their hands are soiled. The Center of Disease Control (CDC) Hand Hygiene Guidance for Hand Hygiene in Healthcare settings dated January 30, 2020, and viewed on January 31, 2023, at 2:25 p.m., recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal. The licensee's Infection Control 8.09 Hand	0 510		

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0 510	Continued From page 4 washing policy dated December 13, 2022, indicated that hand washing shall be completed: - before, during, and after preparing food - before eating food - before and after caring for someone who is sick - before and after treating a cut or wound - after using the toilet - after changing diapers or cleaning up after someone who has used the toilet - after blowing your nose, coughing, or sneezing - after touching an animal or animal waste - after handling pet food or pet treats; and - after touching garbage. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 5 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2023, at 12:20 p.m., the evaluator observed the licensee's emergency preparedness plan behind the nurse station on the desk in a red binder. The licensee's plan contained a flip chart of various emergency situations. The plan contained direction on making an emergency plan	0 680		

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0 680	Continued From page 6 and listed various emergency situations (such as fire, severe weather, bomb threat, internal evacuation, gas explosion, tornado, power outage, missing resident, pandemic influenza resident, staffing contingency plan, falls, death, flood, and intruder). The licensee lacked an emergency preparedness plan to address the following requirements: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. The licensee's EP plan lacked evidence the plan was updated or revised with EP undated. On January 30, 2023, at 12:20 p.m., licensed assisted living director (LALD)-A stated that	0 680		

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0 680	Continued From page 7 licensee had been working on the emergency preparedness plan and stated the plan needed to be updated. The licensee's Emergency Disaster Policy, [no date], indicated the licensee and the director of nursing (DON) developed and coordinated plans with state and local emergency disaster authorities to response to potential emergencies and disasters. The plan outlined the protection or evacuation of all residents and included arrangements for staff response or provision of additional staff to ensure the safety of any resident with physical or mental limitations. The plan directed the DON and the owner/licensee review and update the plan as necessary to conform with local emergency plans. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (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	0 810		

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0 810	Continued From page 8 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 record review and interview, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 810		

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0 810	Continued From page 9 The findings include: A record review and interview were conducted on January 31, 2023, at approximately 1:00 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility A record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. A record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated which part of the building each staff member was responsible for but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. A record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and	0 810		

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0 810	Continued From page 10	0 810		

unusual needs of the residents. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions.

A record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. LALD-A provided meeting minutes for an all-staff meeting held on March 1, 2022, where the topic of fire safety was on the agenda. During the interview, LALD-A stated the licensee did not have any additional documented training or a policy on training employees.

A record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During the interview, LALD-A stated that all current residents at the facility were not physically and/or cognitively capable of assisting in their own evacuation, and therefore she had not provided training to the residents on the actions to take in the event of a fire or similar emergency. LALD-A did not provide any documentation or comment on past or future residents who could assist in their own evacuation. LALD-A stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan.

A record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only

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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
0 810	Continued From page 11 drill conducted recently was on April 7, 2022. During the interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33602	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES	14282 BUSINESS CENTER DRIVE NW ELK RIVER, MN 55330

(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 12 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment with licensee January 25, 2023. On January 30, 2023, the evaluator observed ULP-C assisting residents with morning cares. ULP-C's employee record lacked documented evidence of the following: - Overview of Assisted Living statutes; - Assisted Living bill of rights; - Handling of resident complaints; and - Consumer advocacy services. On January 30, 2023, at 1:45 p.m. licensed assisted living director (LALD)-A reviewed the employee record with evaluator. LALD-A stated ULP-C's record lacked all the required orientation topics. The licensee's Orientation and Training 5.01 Orientation of Staff and Supervisors and Content policy dated July 30, 2021, indicated all [the facility] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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	33602	A. BUILDING: _____ B. WING _____	01/31/2023

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01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure medication was administered as prescribed for two of three residents (R3, R6). 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 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). Findings include: R3 R3's diagnoses included vascular dementia, paroxysmal atrial fibrillation, chronic kidney	01760		

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	33602	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 15 disease, and diabetes mellitus. R3's service agreement B dated November 21, 2022, indicated R3 received assistance with medication administration. R3's prescriber order, signed on December 8, 2022, stated R3 should have received quetiapine 25 milligram (mg) tablet by mouth at bedtime. R3's medication administration record (MAR) dated December 2022, indicated R3's quetiapine 25 mg oral tablet was to be given daily at bedtime. R3's MAR dated December 2022, indicated staff did not administer R3's quetiapine bedtime doses as scheduled for the following dates: December 11, 12, 14, 15, 16, 18, and 19. R3's MAR indicated the reason for the missed doses was the medication was not available. R6 R6's diagnoses included dementia, controlled type 2 diabetes without complications, and glaucoma. R6's service agreement B dated January 11, 2022, indicated R6 received assistance with medication administration. R6's prescriber order, signed January 5, 2023, indicated R6 should receive melatonin 10 mg once daily. R6's MAR dated January 2023, indicated R6's melatonin 10 mg oral tablet should be given once daily at 8:00 p.m.	01760		

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01760	Continued From page 16 R6's MAR dated January 2023, indicated staff did not administer R6's melatonin as scheduled for the following dates: January 13,14, 16, 17, 18, 19, 20, 21, and 22. R6's MAR indicated the reason for the missed doses was the medication was not available. On January 31, 2023, at 2:38 p.m., licensed assisted living director (LALD)-A stated staff are supposed to let the nurse know when a medication is getting low or out of stock so the medication can be followed up on and if the staff do not notify her, then she does not know what needs to be ordered. She stated after talking with her software representative she is now aware of a report she can utilize daily to see if any medications are missing so she can follow up right away. On February 1, 2023, at 11:15 a.m., LALD-A stated via phone interview that R3 and R6 did not have any adverse reactions to missing these medications and no trouble sleeping or increased behaviors were noted in either resident. The licensee's policy Medications and Treatments 7.19 Medication and Supplies - Reordering dated July 15, 2021, indicated when a resident needs medication and/or supplies reordered from the pharmacy or supplier, staff will contact them by faxing, calling, or following the pharmacy's directions for refilling prescriptions or requests. Prior to holidays and weekends the RN or designated staff will, plan ahead for the needs of the residents for refills on prescriptions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 17 days	01760		
01940 SS=F	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: Based on interview and record review, the	01940		

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01940	Continued From page 18 licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for two of three residents (R2, R3) who had ordered 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 30, 2023, at 9:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee offered services to include compression stockings and blood glucose monitoring. R2 R2's diagnoses included vascular dementia, diabetes mellitus, hypertension, chronic kidney disease, and anxiety. R2's service plan agreement B dated September 19, 2022, indicated R2 received assistance with bathing, dressing, special dressing, housekeeping, laundry, grooming, medication administration, record blood glucose, and toileting reminders. R2's 90 day assessment, section therapy and treatment plan, dated January 11, 2023, indicated assistance with compression stockings and blood glucose monitoring.	01940		

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	33602	A. BUILDING: _____ B. WING _____	01/31/2023

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BEEHIVE HOMES	14282 BUSINESS CENTER DRIVE NW ELK RIVER, MN 55330

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01940	Continued From page 19 R2's prescriber order, dated May 18, 2022, included compression stockings. R2's record lacked the following required content: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment 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. R3 R3's diagnoses included vascular dementia, Parkinson's disease, controlled type 2 diabetes, and major depressive disorder. R3's service plan agreement B signed November 21, 2022, indicated R3 received assistance with bathing, behavior management, dressing, laundry, medication administration, toileting, and transfer assist. R3's prescriber order, dated December 8, 2022, included compression stockings. R3's record lacked an individual treatment or therapy plan to include all required content. On January 31, 2023, at 2:33 p.m., LALD-A stated it was likely that all residents with treatments or therapies did not have an individualized treatment plan developed that contained all the required content. LALD-A stated	01940		

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01940	Continued From page 20 she was still learning her computer system and called the computer system online support for assistance with developing treatment plans. The licensee's Medications and Treatments 7.05 Treatment and Therapy Management Plan policy dated July 28, 2021, indicated for each resident at [the facility] receiving management of ordered or prescribed treatments or therapy services, the facility will 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] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 21	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: A record review and interview were conducted January 31, 2022, at approximately 1:00 p.m. with Licensed Assisted Living Director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility.	02040		

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02040	Continued From page 22 Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated the facility had conducted this assessment but was not able to provide documentation or locate the assessment at the time of survey. LALD-A verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/30/23*
Time: 11:28:49
Report: 1037231021

Food and Beverage Establishment Inspection Report

Location:
Beehive Homes
14282 Business Center Drive Nw
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0038872
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635951251
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 168 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: WILD RICE SOUP
Violation Issued: No

Process/Item: Cooking
Temperature: 189 Degrees Fahrenheit - Location: BEAN AND HAM SOUP
Violation Issued: No

Process/Item: Receiving
Temperature: 40 Degrees Fahrenheit - Location: MILK CARTON
Violation Issued: No

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

Type: Full
Date: *01/30/23*
Time: 11:28:49
Report: 1037231021
Beehive Homes

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 inspection report number 1037231021 of 01/30/23.

Certified Food Protection Manager: JANE M. GARDNER

Certification Number: 112966 Expires: 08/25/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231021

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	0	Date	01/30/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:28:49
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Beehive Homes	14282 Business Center Drive Nw	Elk River, MN	55330	7635951251

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038872		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Surpervision			
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:** 01/30/23

Inspector (Signature) Michelle L Thomas