



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 29, 2025

Licensee
Beehive Homes Of Moorhead
1001 Caddy Avenue
Moorhead, MN 56560

RE: Project Number(s) SL34745016

Dear Licensee:

On July 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Benjamin J. Zwart'.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 5, 2025

Licensee
Beehive Homes Of Moorhead
1001 Caddy Avenue
Moorhead, MN 56560

RE: Project Number(s) SL34745016

Dear Licensee:

On April 24, 2025, 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 January 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 23, 2025, found not corrected at the time of the April 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00

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

The details of the violations noted at the time of this follow-up survey completed on April 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2025
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF MOORHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 CADDY AVENUE MOORHEAD, MN 56560			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#34745016-1 On April 22, 2025, through April 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 23, 2025. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by:	{0 340}	Not reviewed during this survey.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food	{0 480}			

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{0 480}	Continued From page 3 and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 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. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	{0 580}	Not reviewed during this survey.		

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{0 580}	Continued From page 4 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	{0 580}	Not reviewed during this survey.		
{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; 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:	{0 630}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records	{0 650}	Not reviewed during this survey.		

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

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{0 680}	Continued From page 6 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	{0 780}			

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{0 780}	Continued From page 7 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 of the residents). Findings include: On a facility tour on April 23, 2025, from 1:00 p.m. to 2:00 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICALLY LOCKED EGRESS DOORS There was a controlled egress locking system	{0 780}			

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{0 780}	Continued From page 8 installed on all exit doors leading out of the assisted living with dementia care to the exterior exit path. There was not an emergency release switch used to directly release the electrically locked doors to open in the direction of egress travel in the event of an emergency. During the tour LALD-A, asked if the fire alarm pull station could serve the same function as the emergency release switch. It was explained to LALD-A, the emergency release button is required to be a separate switch to directly release the door locking system and the fire alarm pull station shall not be used as the emergency release switch. The electrically locked doors were provided with a backup power system designed to prevent the doors from opening with loss of building electrical system power. Electrically locked doors are required to release to the open position with loss of power in accordance with MSFC in Minnesota Rules Chapter 7511, and National Fire Protection Association 72. FIRE-RESISTANT RATED DOORS The spring-loaded hinges on the fire-resistant rated doors in the corridors including, laundry room, and furnace rooms were not working to automatically close and latch the doors. Fire resistant rated doors are required to automatically close and latch to prevent the passage of smoke and fire to the corridor in accordance with MSFC in Minnesota Rules Chapter 7511. COMMERCIAL KITCHEN HOOD AND DUCT	{0 780}			

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{0 780}	Continued From page 9 CLEANING There was no documentation provided indicating the commercial kitchen hood and duct system was inspected and cleaned in accordance with the requirements of MSFC in Minnesota Rules Chapter 7511. During the tour LALD-A, provided an email confirming the kitchen hood was scheduled to be inspected or cleaned and stated documentation was not available indicating the kitchen hood exhaust system was inspected or cleaned as required. MAINTAINED EXIT PATH There were marked exit doors leading to the exterior fenced recreation area with locked gates requiring a key to open and not tied into the special door locking system to fail safe and release to open to exit to the public way with activation of the special door locking system. When the exterior exit gates are provided with a lock the locking hardware shall be operated the same as the building exit doors and special locking arrangement or openable from the direction of egress travel without the use of keys tools or special knowledge. The emergency release button and exterior gate locking hardware is required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. During the facility tour LALD-A, verified the above listed observations while accompanying on the tour.	{0 780}			

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{0 800}	Continued From page 10	{0 800}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on April 23, 2025, from 1:00 p.m. to 2:00 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility disrepair:	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 11 EMERGENCY GENERATOR MAINTENANCE During the tour LALD-A, stated the generator was used as backup power in the emergency preparedness plan and the surveyor requested documentation the generator was serviced as required. During the tour LALD-A, provided documentation the generator was serviced annually, and no other service and testing documentation was provided. On April 23, 2025, LALD-A, provided an email indicating the generator would not be as easy as hoped to test each month. No further information was provided. During the facility tour it was explained the emergency backup power generator is required to be maintained and tested in accordance with MSFC in Minnesota Rules Chapter 7511 and National Fire Protection Association (NFPA) 110. During the facility tour and an interview on April 23, 2025, at 2:00 p.m., LALD-A, stated annual service was available but not full testing and maintenance records based on the requirements of the MSFC and NFPA 110.	{0 800}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office	{0 910}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2025
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{0 910}	Continued From page 12 box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not reviewed during this survey.		
{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide	{0 920}			

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{0 920}	Continued From page 13 specialized diets. This MN Requirement is not met as evidenced by:	{0 920}	Not reviewed during this survey.		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	{01060}			

Minnesota Department of Health

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{01060}	Continued From page 14 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	{01500}			

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{01500}	Continued From page 15 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		

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{01620}	Continued From page 16	{01620}			
{01620} SS=D	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:	{01620}			
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:	{02170}	Not reviewed during this survey.		

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{02170}	Continued From page 17 (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 3, 2025

Licensee
Beehive Homes Of Moorhead
1001 Caddy Avenue
Moorhead, MN 56560

RE: Project Number(s) SL34745016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - \$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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
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0 000	Initial Comments 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: SL34745016-0 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on January 22, 2025, issued for SL34745016-0, tag identification 1290.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1	0 340			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0580, 0650, 0680, 0810, 1500, 1620) for a survey completed on August 3, 2022. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee lacked documentation to indicate correction orders previously cited on August 3, 2022, were in full compliance with assisted living with dementia care statutes. On January 21, 2025, at 11:15 a.m., CNS-B stated the licensee's plan of correction from the previous survey completed on August 3, 2022, may be in a box of stuff at CNS-B's home. CNS-B further stated the licensee had talked about what needed to be done to correct the tags that were issued. On January 22, 2025, at 11:17 a.m., CNS-B stated CNS-B had not been able to locate the licensee's plan of correction, however, the plan of correction may be documented on a different computer at CNS-B's home. On January 23, 2025, the survey concluded, and correction orders 0580, 0650, 0680, 0810, 1500, and 1620 were reissued. No further information was provided.	0 340			

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0 340	Continued From page 3	0 340			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480			

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0 480	Continued From page 5 (FBEIR) dated January 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 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. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485			

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0 485	Continued From page 6 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: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. During the entrance conference on January 21, 2025, at 9:18 a.m., licensed assisted living director (LALD)-A stated the licensee provided residents three meals per day, and the licensee's contract required residents to pay for all meals as part of the resident's monthly fees. On page six of the undated Assisted Living Contract, Section 2: Housing Related Services Available through (licensee name) at an Additional Fee indicated additional meals could be purchased for an additional fee. Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or all meals residents would not want. On January 22, 2025, at 11:26 a.m., CNS-B stated the same assisted living contract was used for all residents, and the assisted living contract required residents to pay for three meals per day with each care package (service package) the licensee offered. CNS-B further stated CNS-B recalled the licensee was notified from a sister facility regarding requiring residents to pay for all three meals as part of the assisted living contract,	0 485			

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0 485	Continued From page 7 however, the licensee had not made any changes to the assisted living contract. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect	0 580			

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0 580	Continued From page 8 all current 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: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. During the entrance conference on January 21, 2025, at 9:35 a.m., CNS-B stated the licensee had a quality management program that was not officially organized, however, the current topic was resident activities. On January 21, 2025, at 11:15 a.m., CNS-B stated the licensee did not have any documentation of the licensee's weekly quality management meetings or current quality management project topics. The licensee's 2.31 Quality Management Project policy dated August 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 580			

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0 580	Continued From page 9 (21) days	0 580			
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; 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 (IAPP) was developed to include the required content for two of two residents (R2, R4). 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: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor	0 630			

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0 630	Continued From page 10 (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes and Lewy Body dementia (progressive decline in mental abilities). R2's service plan dated January 20, 2025, indicated R2 received medication administration, blood glucose monitoring, and assistance with behaviors, grooming, dressing, bathing, toileting, and transfers. On January 22, 2025, at 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration to R2. R2's resident record contained an IAPP dated January 20, 2025, which addressed R2's risk of being abused by others. R4 R4's diagnoses included dementia without behavioral disturbances, chronic obstructive pulmonary disease (COPD-difficult breathing), and depression. R4's service plan dated December 13, 2024, indicated R4 received medication administration, and assistance with behaviors, grooming, dressing, and bathing. On January 22, 2025, at 7:02 a.m., the surveyor observed ULP-F provide scheduled morning medication administration to R4. R4's resident record contained an IAPP dated December 17, 2024, which addressed R4's risk of being abused by others.	0 630			

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0 630	Continued From page 11 R2 and R4's resident record lacked resident's risk of abuse to others and resident's risk for self-abuse. On January 23, 2025, at 12:45 p.m., CNS-B stated the licensee used the same IAPP for all residents at the facility. On January 23, 2025, at 2:21 p.m., CNS-B stated the licensee's IAPP did not address the resident's risk of abusing others or the resident's risk for self-abuse. CNS-B further stated the licensee was aware of all required content in a resident's IAPP, however, the licensee had missed answering two questions to address missing content on all resident IAPP forms. The licensee's 6.05 IAPP policy dated August 1, 2021, indicated a resident IAPP would include the resident's risk of abusing other vulnerable adults, and the resident's risk for self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650			

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0 650	Continued From page 12 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on January 21, 2025, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents for an employee record. ULP-E was hired on September 13, 2024, to	0 650			

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0 650	Continued From page 13 provide direct assisted living services to residents at the facility. On January 22, 2025, at 8:02 a.m., the surveyor observed ULP-E assist R6 with dressing. ULP-E's employee record lacked documentation of training and competency evaluation for medication administration for unplanned time away. In addition, ULP-E's employee record lacked documentation of training for awareness of commonly used health technology equipment and assistive devices. On January 22, 2025, at 7:20 a.m., ULP-E stated ULP-E was trained and competency tested upon hire with CNS-B and registered nurse (RN)-C. On January 22, 2025, at 11:18 a.m., CNS-B stated awareness of commonly used health technology equipment and assistive devices was reviewed with ULPs upon hire, however, all ULP employee records lacked documentation of the training. CNS-B further stated the unplanned time away training and competency was completed during medication training and competencies, however, the licensee did not document the unplanned time away training and competency in the ULP's employee records. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would include all training and in-service education required and/or provided including record of competency testing as required. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training for all ULPs would include awareness of commonly used health technology	0 650			

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0 650	Continued From page 14 equipment and assistive devices. In addition, a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's 7.10 Medication Management-Planned and Unplanned Time Away policy dated August 2, 2024, indicated the RN may delegate unplanned time away to ULPs if the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medications to residents. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described	0 650			

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0 650	Continued From page 15 in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680			

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0 680	Continued From page 16 licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated 2022 lacked the following content and/or policies and procedures to address: - a completed hazards risk assessment; - annual review of the EPP; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - a missing resident plan that was reviewed quarterly; - a description of the population served by the licensee; - shelter in place; - tracking system for residents and staff; and - must conduct exercises to test the EPP at least	0 680			

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0 680	Continued From page 17 twice per year, including unannounced staff drills using the EPP. On January 22, 2025, at 10:52 a.m., licensed assisted living director (LALD)-A stated the licensee had just purchased a new EPP that addressed topics noted above, however, LALD-A had not updated the new EPP specific to the licensee. On January 22, 2025, at 11:33 a.m., CNS-B stated the licensee reviewed the missing resident policy every six months to yearly. CNS-B further stated CNS-B was not sure if the EPP had been updated since the last survey as it was LALD-A's responsibility to keep the EPP up to date. CNS-B stated CNS-B was unsure where documentation of EPP testing drills were kept. On January 22, 2025, at 11:42 a.m., LALD-A stated the EPP had not been updated since 2022 and the licensee only reviewed the missing resident policy on an annual basis. The licensee's undated 2.01 Policies and Procedures Overview (0-009) policy indicated the licensee emergency plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually [sic]. The licensee's undated Missing Resident policy did not address how often the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the LALD and clinical nurse supervisor (CNS) must review the missing person plan at least quarterly and document any changes to the plan.	0 680			

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0 680	Continued From page 18 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780			

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0 780	Continued From page 19 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 of the residents). Findings include: On a facility tour on January 21, 2025, from 11:00 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICALLY LOCKED EGRESS DOORS There was not an emergency release button used to directly release the electrically locked doors to open in the direction of egress travel in the event of an emergency. The emergency release button	0 780			

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0 780	Continued From page 20 is required to be in a location that is constantly attended by staff. The electrically locked doors were provided with a backup power system designed to prevent the doors from opening with loss of building electrical system power. Electrically locked doors are required to release to the open position with loss of power in accordance with MSFC in Minnesota Rules Chapter 7511, and National Fire Protection Association 72. SPACE HEATERS There was a space heater inside resident sleeping room 12 and plugged into the electrical wall outlet. Space heaters are not allowed inside resident rooms in dementia care units in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE-RESISTANT RATED DOORS The spring-loaded hinges on the fire-resistant rated doors in the corridors including resident room, laundry room, and furnace rooms were not working to automatically close and latch the doors. Fire resistant rated doors are required to automatically close and latch to prevent the passage of smoke and fire to the corridor in accordance with MSFC in Minnesota Rules Chapter 7511. COMMERCIAL KITCHEN HOOD AND DUCT CLEANING There was no documentation provided indicating the commercial kitchen hood and duct system was inspected and cleaned in accordance with the requirements of MSFC in Minnesota Rules	0 780			

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0 780	Continued From page 21 Chapter 7511. MAINTAINED EXIT PATH There were marked exit doors leading to the exterior fenced recreation area with locked gates installed and snow cover obstructing the exit path to the public way. The exterior exit path is required to be maintained free of snow cover and provided with gate locking hardware that is operated the same as the building exit doors and openable from the direction of egress travel. The exterior exit path is required to provide unobstructed access continuous to the public way (parking lot, street or public sidewalk), in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511. The emergency release button is required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. During the facility tour LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800			

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0 800	Continued From page 22 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on January 21, 2025, from 11:00 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility disrepair: EMERGENCY GENERATOR MAINTENANCE During the tour LALD-A, stated the generator was used as back up power in the emergency preparedness plan and the surveyor requested documentation the generator was serviced as required. No further information was provided.	0 800			

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0 800	Continued From page 23 During the facility tour and an interview on January 21, 2025, at 2:00 p.m., LALD-A, stated annual service was available but not required weekly and monthly maintenance records. 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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810			

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0 810	Continued From page 24 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. 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 potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 12:10 p.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar	0 810			

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0 810	Continued From page 25 emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on January 21, 2025, at 12:20 p.m., LALD-A, stated the resident procedures required in the event of a fire or similar emergency were not available in writing and evacuation statuses were included in the computer software system but not in writing and immediately available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the training was completed at onboarding but not twice per year after hire. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required resident training was provided to residents. During an interview on January 21, 2025, at 12:25 p.m., LALD-A, stated documentation was not available for employee training twice per year or	0 810			

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0 810	Continued From page 26 for training provided to residents annually. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in August of 2024 only. During an interview on January 21, 2025, at 12:45 p.m., LALD-A, stated the only documentation for evacuation drills completed in 2024 was for August. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced	0 910			

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0 910	Continued From page 27 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R4). This had the potential to affect all 16 residents who received assisted living with dementia care services. 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: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 and R4's Assisted Living Contract were signed on November 20, 2022, and December 2, 2024, respectively. R2 and R4's assisted living contracts lacked the licensee's healthcare facility identification number (HFID). On January 22, 2025, at 11:24 a.m., CNS-B stated the same assisted living contract was used for all residents. CNS-B further stated CNS-B was not sure why the licensee's assisted living contract did not contain the licensee's HFID. No further information was provided.	0 910			

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0 910	Continued From page 28	0 910			
0 920 SS=C	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R4). This had the potential to affect all 16 residents who received assisted living with	0 920			

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0 920	Continued From page 29 dementia care services. 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: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 and R4's Assisted Living Contract were signed on November 20, 2022, and December 2, 2024, respectively. R2 and R4's assisted living contracts lacked a disclosure of the facility's ability to provide specialized diets. On January 22, 2025, at 11:25 a.m., CNS-B stated the same assisted living contract was used for all residents. CNS-B further stated CNS-B was not sure why the licensee's assisted living contract did not address the licensee's ability to provide specialized diets. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			

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01060	Continued From page 30	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

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01060	Continued From page 31 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included diabetes and Lewy Body dementia (progressive decline in mental abilities). R2's service plan dated January 20, 2025, indicated R2 received medication administration, blood glucose monitoring, and assistance with	01060			

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01060	Continued From page 32 behaviors, grooming, dressing, bathing, toileting, and transfers. On January 22, 2025, at 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration to R2. R2's Resident Notes-One Resident included the following entries: -January 2, 2025, at 6:52 p.m., phone call for a nonemergent ambulance to transport R2 to the ER (emergency room). -January 6, 2025, at 12:54 p.m., RN (registered nurse) completed hospital assessment on R2 prior to R2's return to the assisted living facility. R2's Med (medication) Admin (administration) Summary dated January 2025, indicated R2's services were on hold from January 2, 2025, at 6:00 p.m., until January 6, 2025, at 5:00 p.m. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 33 In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 23, 2025, at 12:50 p.m., CNS-B stated R2 was hospitalized, however, an emergency relocation was not done for R2. CNS-B further stated the licensee was not aware of the emergency relocation requirement, including notification to the OOLTC if the resident had not returned to the facility within four days. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) that contains, at a minimum: -The reason for the relocation; -The name and contact information for the location to which the resident has been relocated and any new service provider; -Contact information for the OOLTC; -If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290	Continued From page 34	01290			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of five employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents living within the facility. 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).	01290			

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01290	Continued From page 35 The findings include: This resulted in an immediate correction order on January 22, 2025. During the entrance conference on January 21, 2025, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. ULP-D was hired on December 7, 2023, to provide direct care services to residents at the facility. The licensee's weekly schedules indicated ULP-D worked 18 out of 51 overnights for the licensee from December 1, 2024, through January 18, 2025. ULP-D's employee record lacked a current cleared background study. On January 21, 2025, at 10:52 a.m. through 10:58 a.m., the surveyor reviewed the NETStudy 2.0 website and rosters with licensed assisted living director (LALD)-A. LALD-A stated ULP-D worked independently without supervision, provided direct resident cares on the night shift for the licensee, and ULP-D was not listed on the licensee's NETStudy 2.0 roster. LALD-A searched ULP-D's last name and date of birth on the NETStudy 2.0 website, which resulted in three matches to ULP-D's name and date of birth. LALD-A clicked on each name match for ULP-D, however, the site indicated for each match ULP-D was no longer affiliated with licensee resulting in no background study for ULP-D under the licensee. LALD-A stated the licensee had reached out to the Minnesota Department of Human Services (DHS) with issues when	01290			

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01290	Continued From page 36 entering in ULP-D's background study and social security number after ULP-D was hired. The surveyor requested to review documentation with DHS, and LALD-A stated LALD-A would search for the documentation. On January 21, 2025, at 11:15 a.m., LALD-A stated the licensee would not be informed in ULP-D's NETStudy 2.0 background check came back ineligible since the licensee did not have any background study entered for ULP-D on NETStudy 2.0. On January 21, 2025, at 4:36 p.m., LALD-A emailed (electronic mail) the surveyor. The email indicated LALD-A was unable to locate email correspondence with Minnesota DHS that had a response from Minnesota DHS after ULP-D started employment, and LALD-A was unable to review call logs for the dates and times LALD-A contacted MN DHS regarding ULP-D's background study. LALD-A further wrote the licensee needed to follow through with a corrective action plan and remove ULP-D from the floor until the licensee submitted a background study on NETStudy 2.0 for ULP-D. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. In addition, if hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of (licensee name) except under the direct supervision (eyesight) of another qualified staff person.	01290			

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01290	Continued From page 37 Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 38 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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	01500			

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01500	Continued From page 39 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required annual training content for each 12 months of employment for one of one employee (registered nurse (RN)-C). 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: During the entrance conference on January 21, 2025, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents for an employee record. RN-C was hired on December 12, 2022, to provide direct care services to residents at the facility, along with supervision of staff employed at the facility.	01500			

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01500	Continued From page 40 During the survey on January 21, 2025, through January 22, 2025, the surveyor observed RN-C provide direct care services and interacted with residents at the facility. RN-C's employee record lacked annual review of the facility's policies and procedures relating to the provision of assisted living services, and how to implement those policies and procedures for annual training for the years of 2023 and 2024. On January 21, 2025, at 12:26 p.m., CNS-B stated all employees completed the same annual training and all employee records lacked review of the licensee's policies and procedures. CNS-B further stated CNS-B did not know review of the licensee's policies and procedures was a required annual training topic. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures were a required annual training topic. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=D	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	01620			

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01620	Continued From page 41 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 the registered nurse (RN) conducted comprehensive assessments within 14 days following a residents admission date for one of two residents (R4). In addition, the licensee failed to ensure the RN conducted assessments with the uniform assessment tool that included all required content for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01620			

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01620	Continued From page 42 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 21, 2025, at 9:19 a.m., clinical nurse supervisor (CNS)-B stated upon admission of a resident, the licensee completed a comprehensive assessment on admission, 14 days after admission, and then at least every 90 days unless the resident had a change of condition. R4 was admitted to the facility on December 2, 2024. R4's diagnoses included dementia without behavioral disturbances, chronic obstructive pulmonary disease (COPD-difficult breathing), and depression. R4's service plan dated December 13, 2024, indicated R4 received medication administration, and assistance with behaviors, grooming, dressing, and bathing. On January 22, 2025, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration to R4. During the observation, the surveyor observed a bed alarm on R4's bed. R4's Admission Assessment dated December 2, 2024, was completed by RN-C. The assessment indicated no assistive devices needed for the bed for safety. R4's 14-Day Review (assessment) dated December 17, 2024 (15 days after the admission assessment), was completed by RN-C. The	01620			

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01620	Continued From page 43 assessment indicated no assistive devices needed for the bed for safety. R4's record lacked evidence of a 14-day assessment completed by an RN in the required time frame. In addition, R4's record lacked evidence R4 was assessed to use a bed alarm for safety. On January 23, 2025, at 2:22 p.m., CNS-B stated R4's 14-day assessment was an oversight and should have been completed within 14 days after R4 was admitted to the facility. CNS-B further stated R4's assessment did not address R4's bed alarm and the bed alarm should have been assessed with each of R4's assessments. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all elements of the uniform assessment tool as required. In addition, the resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. The licensee's 6.03 Uniform Assessment Tool policy dated August 1, 2021, indicated (licensee name) will use a uniform assessment tool that addresses all of the required elements. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12).	01620			

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01620	Continued From page 44 B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all	02040			

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02040	Continued From page 45 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted January 21, 2025, at 12:15 p.m., with licensed assisted living director (LALD)-A, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. 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 an interview on January 21, 2025, at 12:45 p.m., LALD-A, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF MOORHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 CADDY AVENUE MOORHEAD, MN 56560			
(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
02170	Continued From page 46 (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for two of two residents (R2, R4) who resided in an assisted living with dementia care facility.	02170			

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02170	Continued From page 47 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license effective March 1, 2024, with an expiration date of February 28, 2025. During the entrance conference on January 21, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes and Lewy Body dementia (progressive decline in mental abilities). R2's service plan dated January 20, 2025, indicated R2 received medication administration, blood glucose monitoring, and assistance with behaviors, grooming, dressing, bathing, toileting, and transfers. On January 22, 2025, at 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration to R2. R2's Individualized Activity Plan dated January 20, 2025, included an evaluation of the activity areas which were required, however, R2's record did not include an individualized activity plan	02170			

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02170	Continued From page 48 specific for R2. R4 R4's diagnoses included dementia without behavioral disturbances, chronic obstructive pulmonary disease (COPD-difficult breathing), and depression. R4's service plan dated December 13, 2024, indicated R4 received medication administration, and assistance with behaviors, grooming, dressing, and bathing. On January 22, 2025, at 7:02 a.m., the surveyor observed ULP-F provide scheduled morning medication administration to R4. R4's Individualized Activity Plan dated December 17, 2024, included an evaluation of the activity areas which were required, however, R4's record did not include an individualized activity plan specific for R4. On January 23, 2025, at 12:46 p.m., CNS-B stated all residents at the facility were encouraged to attend the group activity offered each day. On January 23, 2025, at 2:22 p.m., CNS-B stated the licensee completed an individualized evaluation on each resident, however, CNS-B was not able to locate an individualized activity plan of structured and nonstructured activities specific for each resident. The licensee's 3.05 ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated August 1, 2021, indicated an individualized activity plan must be developed for each resident based on	02170			

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02170	Continued From page 49 their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			



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

Type: Full
Date: 01/21/25
Time: 12:44:40
Report: 1042251003

Food and Beverage Establishment Inspection Report

Page 1

Location:

Beehive Homes Of Moorhead
1001 Caddy Avenue
Moorhead, MN56560
Clay County, 14

Establishment Info:

ID #: 0038676
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185123033
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

Comply By: 01/21/25

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 36.1 Degrees Fahrenheit - Location: Garlic Minced

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 37.2 Degrees Fahrenheit - Location: Pickles

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 38.7 Degrees Fahrenheit - Location: Herring in Wine Sauce

Violation Issued: No

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

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

Type: Full
Date: 01/21/25
Time: 12:44:40
Report: 1042251003
Beehive Homes Of Moorhead

Food and Beverage Establishment Inspection Report

Page 2

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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 1042251003 of 01/21/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Establishment Representative

Signed: _____

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