



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 6, 2025

Licensee

Prelude Homes & Services, LLC
3808 Blackhawk Ridge Place
Eagan, MN 55122

RE: Project Number(s) SL25900016

Dear Licensee:

On April 11, 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 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 15, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 15, 2025, found not corrected at the time of the April 11, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0900-Contract Required-144g.50 Subdivision 1 - \$500.00
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 11, 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.

Also, at the time of this follow-up completed on April 11, 2025, we identified the following violation(s):

0920-Contract Information-144g.50 Subd. 2 (c)

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

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 Jodi Johnson at 507-344-2730.

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 black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: 507-344-2730
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25900	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/11/2025
NAME OF PROVIDER OR SUPPLIER PRELUDE HOMES & SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122		
(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 SL25900016-1 On April 9, 2025, through April 11, 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 15, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and new orders issued.	{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.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 810}	Continued From page 1 (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 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 144G.50 Subdivision 1 Contract required	{0 810}			
{0 900} SS=F		{0 900}	Not reviewed with this survey.		

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{0 900}	Continued From page 2 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a signed contract for all three of the licensee's residents (R4, R5, R6) prior to providing assisted living services as required.	{0 900}			

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{0 900}	Continued From page 3 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 April 11, 2025, at 8:13 a.m., licensed assisted living director (LALD)-D stated a change of ownership was effective on April 1, 2025, and the new owners felt it was in their best interest to start fresh and all residents were considered new admissions. R4 R4 began receiving services from the licensee on April 1, 2025. R4's contract was signed by R4's responsible party on April 11, 2025. R5 R5 began receiving services from the licensee on April 1, 2025. R5's contract indicated the contract had been sent to R5's responsible party on April 8, 2025, at 10:54 a.m., and had been electronically signed by the responsible party on April 11, 2025, at 3:24 p.m. R6 R6 began receiving services from the licensee on April 1, 2025.	{0 900}			

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{0 900}	Continued From page 4 R6's contract was signed by R6 on April 2, 2025. On April 11, 2025, at 1:33 p.m., LALD-D stated the contracts should have been signed prior to providing services; however, the contract was being reworked by the lawyers and was not available yet on April 1, 2025. Since they did not have the new contract available, another version of the contract used at a sister facility was utilized and provided to the residents and/or their responsible parties. LALD-D stated the contracts had not been signed prior to providing assisted living service as required. No further information was provided.	{0 900}			
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	0 920			

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0 920	Continued From page 5 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 disclose 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 for all three of the licensee's residents (R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 11, 2025, at 8:13 a.m., licensed assisted living director (LALD)-D stated a change of ownership was effective on April 1, 2025, and the new owners felt it was in their best interest to start fresh and all residents were considered new admissions. R4 R4 began receiving services under the new license ownership on April 1, 2025.	0 920			

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0 920	Continued From page 6 R4's contract was signed by R4's responsible party on April 11, 2025. R5 R5 began receiving services under the new license ownership on April 1, 2025. R5's contract indicated the contract had been sent to R5's responsible party on April 8, 2025, at 10:54 a.m., and had been electronically signed by the responsible party on April 11, 2025, at 3:24 p.m. R6 R6 began receiving services under the new license ownership on April 1, 2025. R6's contract had been signed by the resident on April 2, 2025. R4, R5, and R6's contracts included - pages identifying [Licensee] Memory Care Cottages; - The entity identified above and in the Summary & Contact Information section of the Assisted Living Contract who is licensed by the Minnesota Department of Health as an assisted living facility with dementia care and who has agreed to provide certain assisted living services to Resident as further described in and pursuant to this Service Plan. On April 11, 2025, at 1:33 p.m., LALD-D stated the contracts should have been signed prior to providing services; however, the contract was being reworked by the lawyers and was not available yet on April 1, 2025. Since they did not have the new contract available, another version of the contract used at a sister facility was utilized and provided to the residents and/or their	0 920			

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0 920	Continued From page 7 responsible parties. LALD-D stated the contracts had not been signed prior to providing assisted living service as required and they contained inaccurate information as it was made for a sister facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for all three of the licensees active residents (R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	{0 970}			

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{0 970}	Continued From page 8 the residents). The findings include: On April 11, 2025, at 8:13 a.m., licensed assisted living director (LALD)-D stated a change of ownership was effective on April 1, 2025, and the new owners felt it was in their best interest to start fresh and all residents were considered new admissions. R4 R4 began receiving services from the licensee's new owners on April 1, 2025. R4's contract was signed by the residents responsible party on April 11, 2025. R5 R5 began receiving services from the assisted living on April 1, 2025. R5's contract indicated the contract had been sent to R5's responsible party on April 8, 2025, at 10:54 a.m., and had been electronically signed by the responsible party on April 11, 2025, at 3:24 p.m. R6 R6 began receiving services from the assisted living on April 1, 2025. R6's contract had been signed by the resident on April 2, 2025. R4, R5, and R6's contracts included: As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless	{0 970}			

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{0 970}	Continued From page 9 Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents. On April 11, 2025, at 1:33 p.m., LALD-D stated the contracts should have been signed prior to providing services; however, the contract was being reworked by the lawyers and was not available yet on April 1, 2025. Since they did not have the new contract available, another version of the contract used at a sister facility was utilized and provided to the residents and/or their responsible parties. LALD-D stated she was aware the contracts contained waivers of liability and that was one of the things that needed to be updated by the lawyer. No further information was provided.	{0 970}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored at the correct temperature per the medication manufacturer recommendations for eye drops.	{01880}			

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{01880}	Continued From page 10 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 initial survey on January 13, 2024, at 12:29 a.m., the surveyor observed a medication refrigerator in the medication room. The refrigerator temperature was checked with licensed practical nurse (LPN)-C and the temperature was 32 degrees Fahrenheit. LPN-C stated it was ok but on the low end and she would adjust it. Located in the refrigerator was the following: - R2's Ozempic 3 milliliter injection pen; - R5's Humira injection pen. The licensee's Service Checkoff List dated January 1-14, 2025, included: - "Please check refrigerator temp in the medication room. If temperature is lower than 32 or higher than 40 please notify management right away as food or medication may spoil." The documented temperatures ranged from 32-40 degrees, with only one day recorded between 36°F to 46°F as recommended by the manufacturers. The licensee's Daily Temperature Log dated April 2025, read "Acceptable temperature range 32-40 F" with the following temperatures recorded: - April 1, 2025 = 33	{01880}			

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{01880}	Continued From page 11 - April 2, 2025 = 34 - April 3, 2025 = 33 - April 4, 2025 = 33 Latanoprost prescribing information dated September 16, 2014, indicated before latanoprost is opened it should be stored in the refrigerator between 2-8 degrees Celsius (36-46 degrees Fahrenheit). On January 14, 2025, at 12:52 p.m., clinical nurse supervisor (CNS)-B stated medications should be stored at the correct temperature. On April 11, 2025, at 1:33 p.m., licensed assisted living director (LALD)-D stated she was unaware the recommended storage temperature for latanoprost was 36-46 degrees Fahrenheit, and currently the only medication in the refrigerator was the latanoprost. No further information was provided.	{01880}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 24, 2025

Licensee

Beacon Home Of Eagan
3808 Blackhawk Ridge Place
Eagan, MN 55122

RE: Project Number(s) SL25900016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25900	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER BEACON HOME OF EAGAN		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122			
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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: SL25900016 On January 13, 2025, through Jaunary 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, 11:41 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website identified a person other than LALD-A was the director of record. During the entrance conference on January 13, 2025, at 11:44 a.m., LALD-A stated the previous LALD left employment about a week prior; however, LALD-A had been at the facility since July 2024. LALD-A stated he had not applied yet for a shared license. No further information was provided.	0 110			

Minnesota Department of Health

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0 110	Continued From page 2	0 110			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 550			

Minnesota Department of Health

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0 550	Continued From page 3 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, at 12:34 p.m. during a facility tour, the surveyor observed a bulletin board by the front entrance that included multiple postings but lacked a posting for the facilities complaint or grievance procedure. Licensed practical nurse (LPN)-C stated there is a Minnesota Adult Abuse Reporting Center (MAARC) posting that was supposed to be posted, she was unsure why it was not. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in	0 640			

Minnesota Department of Health

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0 640	Continued From page 4 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to 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 January 13, 2025, at 12:34 p.m. during a facility tour, the surveyor observed a facility phone on the kitchen counter and there was no 911 posting on or near the phone. Licensed practical nurse (LPN)-C stated she was unaware 911 needed to be posted by the facility phones. No further information was provided. TIME PERIOD FOR CORRECTION:	0 640			

Minnesota Department of Health

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0 640	Continued From page 5 Twenty-One (21) days	0 640			
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 licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

Minnesota Department of Health

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0 680	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan last reviewed January 10, 2025, lacked evidence of the following required content: - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; and - policy to address sewage and waste disposal. On January 15, 2025, at 3:25 p.m., licensed assisted living director (LALD)-A stated there was no identification of the at risk population being served by the facility and there was not a policy for sewage and waste disposal, in the facilities EPP. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

Minnesota Department of Health

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0 810	Continued From page 7 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 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 8 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). On January 15, 2025, director of operations/licensed assisted living director (DO/LALD)-D, 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's FSEP, failed to include the following: The FSEP lacked any plans or diagrams showing the location and number of residents sleeping rooms. Plans/diagrams should be located in the FSEP to aid first responders. STAFF ACTIONS: The FSEP provided was from a third-party provider and had not been updated to the specific facility. The plan included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. RESIDENT ACTIONS:	0 810			

Minnesota Department of Health

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0 810	Continued From page 9 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Unique and unusual resident needs: The FSEP 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 plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 15, 2024, at 2:30 p.m., DO/LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire but was using evacuation drills as training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. O-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 10 On January 15, 2025, at 2:30 p.m., DO/LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900			

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0 900	Continued From page 11 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a signed contract for one of two residents (R6) as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 began receiving services on September 16, 2024. R6's record included a Residency Agreement signed June 18, 2019. This was prior to Assisted Living licensure initiated August 1, 2021. On January 15, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated a new assisted living contract was not signed by R6, or her representative. R6 was transferred from another facility owned by the same company, and R6 should have had a signed assisted living contract. No further information provided.	0 900			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BEACON HOME OF EAGAN		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 900	Continued From page 12	0 900			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have the licensee's health facility identification (HFID) number listed on the contract as required for three of three residents (R2, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Resident Agreement dated December 14,	0 910			

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0 910	Continued From page 13 2021, did not include the licensee's HFID. R4's Resident Agreement dated February 9, 2023, did not include the licensee's HFID. R5's Resident Agreement dated April 19, 2024, did not include the licensee's HFID On January 15, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated the contract would be the same for all residents and it should have included the HFID. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for for three of three residents (R2, R4, R5) residing in the facility.	0 970			

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0 970	Continued From page 14 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Resident Agreement was dated December 14, 2021. R4's Resident Agreement was dated February 9, 2023. R5's Resident Agreement was dated April 19, 2024. R2, R4, and R5's contracts included: 32. PERSONAL PROPERTY Resident agrees that Landlord is not responsible for any loss or damage to Resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Landlord's control. 34. LIABILITY Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Suite or on the premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of Resident's	0 970			

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0 970	Continued From page 15 receipt of health-related, supportive or other services from third-party providers. Landlord may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Suite or on the community premises." On January 15, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated the contract would be the same for all residents and they would have to remove the waivers of liability. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	01440			

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01440	Continued From page 16 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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 direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of one 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on December 11, 2023, to provide direct cares to residents and worked a full time schedule. On January 14, 2025, at 8:59 a.m. the surveyor observed ULP-E assisting R6 with personal cares and then transferred R6 from bed to wheelchair using a mechanical lift device.	01440			

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01440	Continued From page 17 On January 14, 2024, at 11:35 a.m., the surveyor observed ULP-E assist R2 to apply her prosthesis. On January 15, 2025, at 3:10 p.m., licensed assisted living director (LALD)-A stated ULP-E was a full time employee and should have had the supervision completed within 30 days of providing delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530			

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01530	Continued From page 18 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-E received the required dementia care training. 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: ULP-E was hired on December 11, 2023, to provide direct cares to residents and worked a full time schedule at the assisted living facility. On January 14, 2025, at 8:11 a.m. the surveyor observed ULP-E assisting R4 with personal cares. On January 14, 2025, at 8:59 a.m., the surveyor observed ULP-E assisting R6 with personal cares and then transferred R6 from bed to wheelchair using a mechanical lift device. On January 14, 2024, at 11:35 a.m. the surveyor observed ULP-E assisting R2 to apply her	01530			

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01530	Continued From page 19 prosthesis. ULP-E's employee record included 1 hours, 43 minutes of dementia training with an online training module. On January 15, 2025, at 2:19 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have the required eight hours of dementia training. All staff completed the same training for dementia so they would not have the required eight hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
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	01620			

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01620	Continued From page 20 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) completed a comprehensive assessment within 14 days of starting services as required for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 began receiving services on September 16, 2024. On January 14, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-E assisting R6 with personal cares and then transferred R6 from bed to wheelchair using a mechanical lift device. R6's Service Plan dated September 17, 2024, indicated R6's services included bathing, dressing grooming, transfer assist with a hoyer lift	01620			

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01620	Continued From page 21 (mechanical full body lift), medication management, medication administration. R6's record identified a comprehensive assessment on September 17, 2024, and a 90-day assessment on December 9, 2024. R6's record lacked evidence a 14-day assessment had been completed. On January 15, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated staff should have completed a 14-day assessment on R6. It had not been completed as R6 had moved from another licensed facility owned by the same company; therefore, staff had treated R6 as a transfer and not as an admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications,	01700			

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01700	Continued From page 22 allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to have a medication assessment for three of three residents (R2, R5, R6) that included interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications to prevent diversion of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 On January 14, 2025, at 9:49 a.m. the surveyor	01700			

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01700	Continued From page 23 observed unlicensed personnel (ULP)-F administer oral and topical medications to R2. R2's Level of Care Assessment dated December 13, 2024, indicated R2 required medication administration of oral and topical medications. R2's assessment failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications. R5 On January 14, 2025, at 7:45 a.m., the surveyor observed ULP-F administer oral medications to R5. R5's Level of Care Assessment dated October 30, 2024, indicated R5 required medication administration of oral and topical medications. R5's assessment failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications. R6 On January 14, 2025, at 8:47 a.m. the surveyor observed ULP-F administer an inhaled medication to R6. R6's Level of Care Assessment dated dated December 9, 2024, indicated R6 required medication administration of oral medications. R6's assessment failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications. On January 15, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the assessments were missing the required diversion information and it	01700			

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01700	Continued From page 24 should have been included in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730			

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01730	Continued From page 25 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure individual medication management plans contain all the required content for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 14, 2025, at 8:47 a.m. the surveyor observed unlicensed personnel (ULP)-F administer an inhaled medication to R6. R6's Level of Care Assessment dated December 9, 2024, indicated R6 required medication administration of oral medications. R6's assessment did not include administration of inhaled medications was delegated to ULPs	01730			

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01730	Continued From page 26 On January 15, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated R6's assessment should have included delegation of inhaled medications to unlicensed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25900	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER BEACON HOME OF EAGAN		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122			
(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
01760	Continued From page 27 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's service agreement dated December 19, 2024, included medication administration. R5's physician orders dated November 18, 2024, included: - levothyroxine 125 mcg give one tablet before breakfast; and - pantoprazole 40 mg one capsule before meals. R5's medication administration record dated January 1-14, 2025, included: - levothyroxine 125 mcg give one tablet before breakfast scheduled at 8:00 a.m. with the rest of R5's morning medications; and - pantoprazole 40 mg one capsule before meals scheduled at 8:00 a.m. with the rest of R5's morning medications. On January 14, 2025, at 7:45 a.m., the surveyor observed ULP-F administer oral medications to R5. ULP-F stated R5 has so many medications that ULP-F will give her half of them and wait a little while and give her the other half of the medications so it does not overwhelm R5. The medications administered at 7:45 a.m. included levothyroxine 125 micrograms (mcg) give one tablet before breakfast. ULP-F brought the medications to the dining room table. R5 had finished her cereal for breakfast. ULP-F removed the bowl and administered the oral medications, including the levothyroxine.	01760			

Minnesota Department of Health

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01760	Continued From page 28 On January 14, 2025, at 8:46 a.m., the surveyor observed ULP-F administer the rest of R5's oral medications, which included pantoprazole 40 milligrams (mg) one capsule before meals. R5's levothyroxine and pantoprazole were not administered before meals as ordered. On December 14, 2025, at 12:52 p.m., clinical nurse supervisor (CNS)-B stated R5's levothyroxine and pantoprazole should be given before meals as ordered, and she would change the times. The licensee's Medication Administration Policy dated February 12, 2024, indicated all medications would be administered according to the six rights of medication administration which included right resident, right medication, right dose, right route, right date and time, and right documentation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880			

Minnesota Department of Health

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01880	Continued From page 29 review, the licensee failed to ensure medications were stored at the correct temperature per the medication manufacturer recommendations for the licensee's two residents with refrigerated medications (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 13, 2024, at 12:29 a.m., the surveyor observed a medication refrigerator in the medication room. The refrigerator temperature was checked with licensed practical nurse (LPN)-C and the temperature was 32 degrees Fahrenheit. LPN-C stated it was ok but on the low end and she would adjust it. Located in the refrigerator was the following: - R2's Ozempic 3 milliliter injection pen; - R5's Humira injection pen. The licensee's Service Checkoff List dated January 1-14, 2025, included: - "Please check refrigerator temp in the medication room. If temperature is lower than 32 or higher than 40 please notify management right away as food or medication may spoil." The documented temperatures ranged from 32-40 degrees, with only one day recorded between 36°F to 46°F as recommended by the manufacturers.	01880			

Minnesota Department of Health

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01880	Continued From page 30 Ozempic prescribing information dated December 2017, indicated "Store your new, unused Ozempic pens in the refrigerator between 36°F to 46°F". Humira prescribing information dated August 2018 indicated "Store HUMIRA in the refrigerator between 36°F to 46°F (2°C to 8°C). Store HUMIRA in the original carton until use to protect it from light. Do not freeze HUMIRA. Do not use HUMIRA if frozen, even if it has been thawed." On January 14, 2025, at 12:52 p.m., clinical nurse supervisor (CNS)-B stated medications should be stored at the correct temperature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940			

Minnesota Department of Health

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01940	Continued From page 31 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 14, 2025, at 9:49 a.m. the surveyor observed unlicensed personnel (ULP)-F completing wound care to R2's right leg stump. ULP-E cleaned the wound and patted dry, applied	01940			

Minnesota Department of Health

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01940	Continued From page 32 Aquaphor, and then applied a gauze pad and secured it with tape. R2's Service Plan dated December 16, 2024, indicated R2's services included Medication management and administration, application of prosthesis, bathing, and stand by assist for mobility. R2's Service Agreement did not include wound care. R2's physician orders dated November 18, 2024, included wound care to left flank area and upper right leg. R2's physician orders dated January 10, 2025, included wound care to stump: - Cleanse area with warm water and gentle cleanser. Pat dry. - Apply Aquaphor or similar barrier cream to open areas - Cover with gauze and secure with tape - Change dressing daily On January 15, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated the wound care had not been added to R2's service plan. When wound care was ordered, the service plan should have been updated and signed by R2. The licensee's Service Plan policy dated May 30, 2024, indicated all services would be included in the service plan and the service plan would be revised as needed with changes in service the resident receives. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Minnesota Department of Health

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02240	Continued From page 33	02240			
02240 SS=E	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not	02240			

Minnesota Department of Health

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02240	Continued From page 34 retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for two of three residents (R2, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services on April 12, 2019, under the licensees Comprehensive Home Care license, and then the Assisted Living license on August 1, 2021. On January 14, 2025, at 9:49 a.m., the surveyor observed unlicensed personnel (ULP)-F administer oral and topical medications to R2.	02240			

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02240	Continued From page 35 R2's record identified an acknowledgement R2 received the Minnesota Home Care Bill of Rights for Assisted Living Clients dated August 1, 2021. R2's record lacked evidence she had received the Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022. R6 R6 began receiving services on September 16, 2024. On January 14, 2025, at 8:47 a.m., the surveyor observed ULP-F administer medications to R6. R6's record included a Residency Agreement signed June 18, 2019. This was prior to Assisted Living licensure initiated August 1, 2021. On January 15, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated a current Minnesota Bill of Rights acknowledgement could not be found for R2. LALD-A stated R6 was not given a new Bill of Rights when they moved into the facility because R6 was 'transferred' from another facility owned by the same company. R6 should have been provided a new Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			



Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 01/14/25
Time: 12:00:00
Report: 1005251010

Food and Beverage Establishment Inspection Report

Page 1

Location:

Beacon Home of Eagan
3808 Blackhawk Ridge Place
Eagan, MN 55122
Dakota County, 19

Establishment Info:

ID #: 0037650
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517147075
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/SALAMI
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 30 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH LALD AND REVIEWED WITH HRD NURSING EVALUATOR STACY HAAG.

THE FACILITY'S CERTIFIED FOOD PROTECTION MANAGER LEFT APPROXIMATELY 1 WEEK AGO. EMPLOY A NEW CFPM WITHIN 60 DAYS. BRIAN HAS CURRENT SERVSAFE CERTIFICATE AND WILL APPLY FOR MN CFPM.

A MAXIMUM REGISTERING TEMPERATURE INDICATOR WAS ON SITE AND OPERATOR

Type: Full
Date: 01/14/25
Time: 12:00:00
Report: 1005251010
Beacon Home of Eagan

Food and Beverage Establishment Inspection Report

Page 2

LATER SENT INSPECTOR A PICTURE AFTER IT WAS RUN THROUGH THE DISHWASHER, AND A UTENSIL SURFACE TEMPERATURE OF 170 DEGREES F WAS ACHIEVED.

THERE ARE TWO ADDITIONAL REFRIGERATORS AND ONE CHEST FREEZER IN THE GARAGE. DURING INSPECTION ALL FOODS WERE FROZEN.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND THE CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005251010 of 01/14/25.

Certified Food Protection Manager: _____

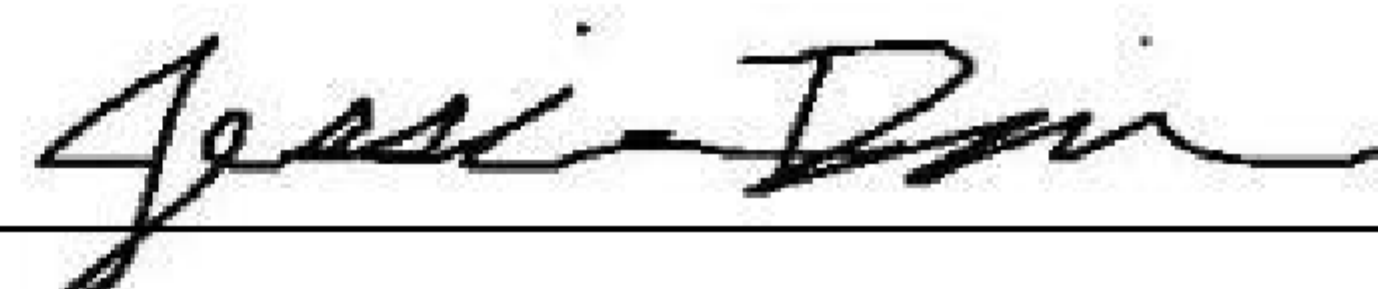
Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

BRIAN BURWELL
LALD

Signed: _____



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