Electronically Delivered

January 3, 2024

Licensee
Bayda Group Home Inc.
1218 East 26th Street
Minneapolis, MN 55404

RE: Project Number(s) SL36424015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH 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.

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

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 the 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36424	A. BUILDING: _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYDA GROUPD HOME INC	1218 EAST 26TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36424015 On December 11, 2023, through December 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; three receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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

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0 470	Continued From page 2 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 December 11, 2023, at 12:00 p.m. during the entrance conference, owner (O)-A stated being unsure if the staffing schedule was posted in a central location for residents and visitors. O-A and the surveyor toured the main floor of the residence at that time and were unable to find evidence of a daily posted staffing schedule. On December 12, 2023, at 12:14 p.m. O-A provided a copy of the licensee's undated, Staffing Plan. O-A stated he did not have evidence the plan had been reviewed twice yearly and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 3 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 12, 2023, 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		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 4 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 interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (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 began providing direct care services for the licensee on May 3, 2022. ULP-D's record lacked an annual performance review. On December 12, 2023, at 3:19 p.m. owner (O)-A	0 650		

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0 650	Continued From page 5 reviewed ULP-E's employee file and could not find evidence of a current performance review. The licensee's Personnel Records policy dated August 1, 2021, indicated a personnel record will be started for each staff member upon hire and will include performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 6 for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This had the potential to affect all current residents living in 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: The licensee's TB facility risk assessment dated January 5, 2023, indicated the licensee was a low risk. ULP-D ULP-D was hired September 5, 2023, to provide direct care services. On December 12, 2023, at 2:06 p.m. ULP-D was observed administering oral medication to R1. ULP-D's employee file lacked evidence of a TB symptom screen. ULP-E ULP-E was hired May 3, 2022, to provide direct care services. ULP-E's employee file lacked evidence of a TB symptom screen.	0 660		

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0 660	Continued From page 7 On December 12, 2023, at 3:19 p.m. owner (O)-A reviewed ULP-D and ULP-E's employee files and could not find evidence of a TB symptom screen. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated: Baseline TB screening at the time of hire is required for all HCWs (health care workers) in Minnesota. Baseline TB screening consists of three component: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and (3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST (tuberculin skin test) or single TB blood test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (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 (EP) plan with all the required content. This had the potential to affect 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 9 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's emergency preparedness plan last reviewed January 20, 2023, lacked the following required content: - Emergency prep testing requirements On December 12, 2023, at 11:31 a.m. owner (O)-A stated the only emergency prep testing conducted at the residence was fire drills. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated: 15. A disaster drill is conducted at the residence at least annually. Result of the drill will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 10 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to conduct monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. 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 December 11, 2023, at 3:23 p.m., with owner (O)-A, survey staff observed the fire extinguishers throughout the facility, did not have current tags or documentation to indicate monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. On December 11, 2023, at 3:23 p.m., O-A verbally confirmed fire extinguishers lacked monthly inspections. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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01370	Continued From page 11	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 12 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-D) to include all required content. 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-D was hired on September 5, 2023, to provide direct care services to residents of the facility. On December 12, 2023, at 2:06 p.m. ULP-D was observed administering oral medication to R1. ULP-D's employee record lacked documentation of training for the following topics: - standby assistance techniques, and how to perform them; - medication, exercise, and treatment reminders; and - preparation of modified diets as ordered by a licensed health professional. On December 12, 2023, at 3:19 p.m. owner (O)-A	01370		

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BAYDA GROUPD HOME INC	1218 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01370	Continued From page 13 reviewed ULP-D's employee file and was unable to find evidence of the above trainings. The licensee's Staff Competency policy dated August 1, 2021, indicated: 3. Training and competency evaluation for all unlicensed personnel include the following. g. Standby assistance techniques and how to perform them h. Medication, exercise and treatment reminders i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 14 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-D) to include all required content. 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-D was hired on September 5, 2023, to provide direct care services to residents of the facility. On December 12, 2023, at 2:06 p.m. ULP-D was observed administering oral medication to R1. ULP-D's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation - range of motioning and positioning The licensee's Staff Competency policy dated August 1, 2021, indicated: 4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency	01380		

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01380	Continued From page 15 evaluation program will demonstrate competency through the following process: a. Satisfactory completion of an oral or written test on the task the HHA will perform. Refer to the Competency Manual for criteria. b. Home Health Aides may not work for [licensee name] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: vii. Safe transfer techniques and ambulation viii. Range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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. (b) The direct supervision of staff performing delegated tasks must be provided within 30	01440		

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01440	Continued From page 16 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 direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-D). 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-D was hired on September 5, 2023, to provide direct care services to residents of the facility. On December 12, 2023, at 2:06 p.m. ULP-D was observed administering oral medication to R1. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee.	01440		

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01440	Continued From page 17 On December 12, 2023, at 3:19 p.m. owner (O)-A reviewed ULP-D's employee record and could not find evidence of a 30-day supervision of a delegated task by the RN. The licensee's Service Plan form dated June 2021, indicated: Staff will have direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks to an assisted living resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	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	01500		

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01500	Continued From page 18 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 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		

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01500	Continued From page 19 Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (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 May 3, 2022, to provide direct care services to residents of the facility. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults; - Assisted Living bill of rights; - Infection control techniques; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery On December 12, 2023, at 3:19 p.m. owner (O)-A reviewed ULP-E's employee record and could not find evidence of the above required content. The licensee's Staff Orientation and Education policy dated August 1, 2021 indicated: 12. All staff providing assisted living services will complete at least eight (8) hours of education for	01500		

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01500	Continued From page 20 every (12) months of employment. 13. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them. d. Infection control techniques i. Implementation of infection control standards based on current recommendation per the CDC (Centers for Disease Control) f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	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	01530		

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01530	Continued From page 21 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP-E) completed at least two hours of dementia training annually 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: ULP-E was hired on May 3, 2022, to provide direct care services to residents of the facility. ULP-E's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required.	01530		

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01530	Continued From page 22 On December 12, 2023, at 3:19 p.m. owner (O)-A reviewed ULP-E's employee record and could not find evidence of the above required content. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated: 12. All staff providing assisted living services will complete at least eight (8) hours of education for every (12) months of employment. 13. Education topics will include, but not be limited to, the following e. 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 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 23 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of one resident (R1), and failed to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of one resident (R1). 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: R1's diagnoses included fetal alcohol syndrome, bipolar disorder, attention deficit hyperactivity disorder, and obsessive-compulsive disorder. R1's Service Plan dated June 13, 2022, indicated	01620		

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01620	Continued From page 24 the resident received services including medication administration, bathing, grooming, dressing, meals, laundry, and light housekeeping. R1's last three assessments were requested. Assessments dated January 26, 2023, December 12, 2022, and September 10, 2022, were provided and reviewed by the surveyor on December 12, 2023. 320 days had passed since R1's last assessment dated January 26, 2023. 94 days had passed since R1's previous two assessments dated September 10, 2022, and December 12, 2022. In addition, these assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. On December 12, 2023, at 9:45 a.m. licensed assisted living director (LALD)-B reviewed R1's assessments dated December 12, 2022, and September 10, 2022. LALD-B stated the assessments were not comprehensive containing all criteria in the Uniform Assessment Tool. LALD-B further stated to his knowledge, the one page form utilized for the assessments was what the former RN routinely used for 14-day, 90-day, and change of condition assessments for all residents. LALD-B stated the new RN for the facility had started less than two weeks prior, and he would inform her of the need to use the Uniform Assessment Tool for all resident assessments. The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of	01620		

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01620	Continued From page 25 this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs. - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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01770	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R1). 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 December 11, 2023, at 12:00 p.m. owner (O)-A confirmed the licensee provided medication management services to the licensee's residents, including medication setup. R1's Service Plan dated June 13, 2022, indicated R1 received daily medication administration by unlicensed personnel and the registered nurse (RN). On December 11, 2023, at 1:59 p.m. the surveyor observed the locked medication closet with clinical nurse supervisor (CNS)-C. A weekly medi-minder (a storage system for setting up medications on a daily basis at specific times for a week duration) was observed on top of the storage bin containing R1's medications. The medications included: levothyroxine (low thyroid) 175 micrograms (mcg) by mouth (po) daily, multivitamin po daily, sertraline (antidepressant)	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36424	A. BUILDING: _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYDA GROUPD HOME INC	1218 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01770	Continued From page 27 150 milligrams (mg) po daily, naltrexone (for alcohol dependence therapy) 50 mg po twice daily, guanfacine HCl (high blood pressure) 2 mg po twice daily, metformin ER (extended release-high blood sugar) 500 mg po daily with dinner, gabapentin (treatment of seizure disorders or nerve pain) 300 mg po three times a day, mirtazpine (antidepressant) 7.5 mg po at bedtime, ziprasidone (antipsychotic) 60 mg po twice a day, trazodone (antidepressant) 150 mg po at bedtime, hydroxyzine HCl (antianxiety) 100 mg po at bedtime. CNS-C stated she set-up R1's medications weekly in the medi-minder for the unlicensed personnel (ULP) to administer. CNS-C further stated doing the same for the other two residents in the home. When asked to seeing documentation of R1's medication set-up, CNS-C stated she documented R1's medication set up had been completed each week in a progress note. This did not include the medication name, quantity of dose, times, or the route. CNS-C further stated this was the process for all medication set ups, and after reviewing the statute agreed the process needed to be changed. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated: 1. As specified in the resident's medication management program, a licensed nurse will regularly set up medications in a clearly labeled container based on the resident's medication regimen. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		

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	36424	A. BUILDING: _____ B. WING _____	12/12/2023

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01910	Continued From page 28	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged 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, 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	01910		

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	36424	A. BUILDING: _____ B. WING _____	12/12/2023

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01910	Continued From page 29 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The discharge resident roster provided by the licensee, indicated R2 had moved to a group home on October 4, 2023. R2's Service Plan/Care Plan dated July 18, 2023, indicated services included medication administration. R2's Medication discharged with [resident name] form dated October 4, 2023, included medications that had been sent with R2. The document identified the medication name, strength, quantity, and signature of the nurse(s). The document did not include the prescription number for any of the medications including: levothyroxine (thyroid hormone replacement), Omega-3 fish oil (supplement), omeprazole (used to treat certain stomach and esophagus problems), Vitamin B12 (supplement), metformin ER (extended release - to treat diabetes) , vitamin D3 (supplement), ascorbic acid (vitamin C supplement), aspirin, Austedo (to decrease involuntary movements), divalproex ER (anticonvulsant, also used for mood stabilization), docusate sodium (stool softener), furosemide (diuretic-water pill), gabapentin (anticonvulsant), Jardiance (antihyperglycemic-to treat diabetes), potassium chloride (supplement), quetiapine (antipsychotic), amitriptyline (antidepressant), rosuvastatin calcium (to treat high cholesterol), fluphenazine (antipsychotic), lorsartan (hypertension), Trulicity (antihyperglycemic), Lantus insulin, acetaminophen, albuterol sulfate inhaler, ibuprofen, nitroglycerin (chest pain), and hydroxyzine pamoate (anti-anxiety).	01910		

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	36424	A. BUILDING: _____ B. WING _____	12/12/2023

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01910	Continued From page 30 On December 12, 2023, at 8:35 a.m. owner (O)-A provided the above form to the surveyor. O-A reviewed the form and stated it did not include the prescription number for R2's listed medications. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated: 5. Upon disposition, [licensee name] will document the following information in the clinical record a. Name, strength, and prescription number of medication, as applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02240 SS=C	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	02240		

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02240	Continued From page 31 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 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 and a written acknowledgement was received for one of one resident (R1). 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	02240		

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	36424	A. BUILDING: _____ B. WING _____	12/12/2023

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BAYDA GROUPD HOME INC	1218 EAST 26TH STREET MINNEAPOLIS, MN 55404

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02240	Continued From page 32 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living services on June 16, 2022. R1's contract included a section signed by R1 on June 13, 2022, verifying a copy of the 144G.01 Assisted Living Bill of Rights had been received. R1's record included a copy of the Assisted Living Bill of Rights received by the resident. The copy was dated November 2019, and was not the most current version. On December 12, 2023, at 3:19 p.m. owner (O)-A stated the November 2019, Assisted Living Bill of Rights was the version provided to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	02290		

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02290	Continued From page 33 Based on interview and record review, the licensee limited the rights of one of one resident (R1) when the licensee required the resident or their representative to sign a Resident Agreement. 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 December 11, 2023, at 12:00 p.m. owner (O)-A stated the residents have a 9:00 p.m. "curfew" and are expected to be back to the facility by that time. R1's diagnoses included fetal alcohol syndrome, bipolar disorder, attention deficit hyperactivity disorder, and obsessive compulsive disorder. R1's Service Plan dated June 13, 2022, indicated the resident received services including medication administration, bathing, grooming, dressing, meals, laundry, and light housekeeping. R1's record included a document titled, Resident Agreement dated January 26, 2023. The document indicated: All residents of [licensee name] must agree and abide by all House Rules. Residents who violate this agreement or any other agreement result in a write up or discharge. By signing this document, you agree to abide by these or any other rules of [licensee name]. All residents are expected to	02290		

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02290	Continued From page 34 follow House Rules while residing at [licensee name]. A copy of these rules is posted in the living room hallway for your convenience. Breaking any of the house rules may result in an immediate notice to vacate the premises. General Rules 1. No smoking inside bedrooms or inside the home. 2. No illegal drugs/alcohol in or around [licensee name]. 3. No stealing or destruction of property. 4. Pets are not allowed unless there is an agreement with the Housing Manager. 5. Resolve conflict without fighting. Bring conflicts to the attention of the staff. 6. Treat each other's personal space, property & feelings with respect. 7. No stealing or unauthorized use of other people's stuff. 8. No loud music except by permission of other people in the home. 9. No swearing or cursing in the home. No sexual comments or behaviors. 10. Knock or request permission before entering someone else's bedroom. 11. No explicit or pornographic materials in any areas of the home. 12. ALWAYS inform staff when planning to leave the property. 13. No loud music in the home. 14. No pork will be served in this company. 15. Residents must request permission for visitors to go in their personal bedrooms. 16. No overnight stays of residents outside the home without written permission. 17. No overnight stays of guests without written permission. On December 12, 2023, at 3:19 p.m. (O)-A stated all residents were required to sign the Resident	02290		

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02290	Continued From page 35 Agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/12/23*
Time: 10:25:00
Report: 103923191

Food and Beverage Establishment Inspection Report

Location:
Bayda Group Home Inc
1218 East 26th Street
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0038165
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126443444
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.

AN EMPLOYEE HAS RECENTLY COMPLETED AN APPROVED FOOD SAFETY COURSE. SUBMIT DOCUMENTATION TO MDH TO BECOME A CFPM. GUIDANCE DOCUMENT ON CFPM PROGRAM SENT WITH REPORT.

Comply By: 12/29/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

OBSERVED SCOOP IN ICE MAKER WITH HANDLE TOUCHING ICE. GAVE GUIDANCE ON PREVENTING CONTAMINATION OF ICE FROM HAND. SCOOP MOVED TO A CLEAN BOWL BESIDE ICE MAKER.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = >100 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *12/12/23*
Time: 10:25:00
Report: 103923191
Bayda Group Home Inc

Food and Beverage Establishment Inspection Report

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the persons-in-charge and reviewed with MDH nurse evaluator Wendy Buckholz

The establishment has a residential kitchen and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, tile floor, painted walls and ceiling and laminate countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

A residential dish machine is located in the kitchen. A weekly log of thermo-stickers shows the dish machine rinse temperature is >160 degrees F.

A supply of single-use gloves is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, orders on report.

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 103923191 of 12/12/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Mohammed Hussein
Person-in-charge

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us