Electronically Delivered

November 17, 2022

Administrator
Beehive Homes of Duluth
4014 Trinity Road
Duluth, MN 55811

RE: Project Number(s) SL31350015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31350	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

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0 000	Initial Comments 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: SL#31350015 On, November 7, 2022, through November 9, 2022, 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 39 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for 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	0 470		

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0 470	Continued From page 1 determining its staffing level that: (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 develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. 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	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility dementia care license. The facility was licensed for a capacity of 41 and had a current census of 39 residents. During entrance conference on November 7, 2022, at 10:35 a.m., registered nurse (RN)-B stated the licensee had a written nursing guideline the licensee uses to determine staffing needs. On November 7, 2022, at 12:08 p.m., during a tour of the facility the surveyor did not observe a posted staff schedule. The licensed assisted living director (LALD)-A stated the staffing schedule was written on a whiteboard in the locked office by the main entrance. LALD-A stated when visitors come into the building, if they ask who is working, we let them know. LALD-A confirmed the staffing schedule was not posted in an area that could be accessed by the residents, staff, and visitors. On November 7, 2022, at approximately 3:00 p.m., RN-B provided the surveyors with a packet titled "Nursing Guidelines" and within the packet was an undated document titled "Staffing". RN-B stated the "Staffing" document was the licensee's staffing plan. The staffing plan indicated adequate staffing as follows: -days - minimum of five (5);	0 470		

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0 470	Continued From page 3 -afternoons - minimum staff of five (5); -NOC (nights) - minimum of three (3); and -ideal number of staff for days and afternoons was six (6) to seven (7) and for NOC shift four (4) staff. The licensee's staffing plan did not include: -evidence of any staffing metrics were used to determine appropriate staffing levels; and -evidence the staffing plan was reviewed twice a year. On November 7, 2022, at 3:26 p.m., RN-B stated the licensee had not developed a written staffing plan that was reviewed twice a year. No further information was provided. TIME PERIOD OF 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report dated November 8, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510		

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0 510	Continued From page 5 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel (ULP-C) during personal cares for R3. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 November 7, 2022, at 1:09 p.m., the surveyor observed ULP-C and ULP-E enter R3's room and don a pair of gloves. ULP-C and ULP-E transferred R3 with a mechanical lift from her chair to her bed. ULP-C and ULP-E proceeded to provide incontinence care for R3. ULP-C and ULP-E lowered R3's pants and partially removed R3's brief. ULP-E assisted R3 on to her left side while ULP-C confirmed R3 had been incontinent of bowel and bladder. ULP-C using gloved hands and several disposable wipes and cleansing foam cleaned R3's bottom and provided peri-care. The surveyor did not observe ULP-C to remove her gloves and perform hand hygiene following incontinence care. With the same gloved hands	0 510		

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0 510	Continued From page 6 ULP-C placed about a 50-cent piece amount of barrier cream on her gloved hand and using the other gloved hand applied the barrier cream to R3's bottom. ULP-C removed her gloves and donned a new pair of gloves (did not perform hand hygiene after removing her gloves). ULP-C and ULP-E proceeded to apply a new brief, remove R3's pants, placed heel protectors (a medical device usually constructed of foam, gel, or fiber-filling, and is designed to offload pressure from the heel) on both of R3's heels, floated R3's heels on pillows and pulled the resident's bed covers up. ULP-C and ULP-E removed their gloves and used hand sanitizer when exiting R3's room. On November 7, 2022, at 1:20 p.m., directly following the above observation, ULP-C stated she had not changed her gloves and performed hand hygiene after she had provided incontinence care and prior to applying the barrier cream to R3's bottom. ULP-C stated, "I should have". ULP-C stated she was aware hand hygiene should be done each time gloves are removed. On November 7, 2022, at 3:19 p.m., registered nurse (RN)-B stated her expectations were for staff to change gloves and perform hand hygiene after providing incontinence cares, prior to providing barrier cream, and after removal of the gloves. The licensee's Hand Washing policy dated March 15, 2022, noted hands should be washed after removing gloves. The licensee's Procedure for Using Gloves policy dated March 15, 2022, noted if gloves become torn or heavily soiled and additional tasks must be performed for the resident, then change the	0 510		

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0 510	Continued From page 7 gloves (washing hands before putting on new gloves before starting the next task). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 39 residents receiving assisted living dementia care services. 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	0 580		

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0 580	Continued From page 8 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 November 7, 2022, at 10:43 a.m., with the licensed assisted living director (LALD)-A, and registered nurse (RN)-B, a request was made to review documentation of the licensee's quality management activities. LALD-A and RN-B confirmed the licensee had not formalized or have documentation of ongoing quality management activities relevant to the size and services provided by the assisted living. The licensee's Quality Management Plan policy dated March 15, 2022, indicated the Quality Council meetings would be held at least quarterly to identify and review dashboard and other quality measures, set goals and identify needed changes in procedures or training staff. The licensee would retain Quality Council documents for two (2) years and would be made available to the Minnesota Department of Health upon request. Documents would include a summary of Council meeting minutes, dashboard/quality metric trends and other relevant information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 9 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4's diagnoses included late onset Alzheimer's dementia, osteoarthritis, stage three (3) chronic kidney disease, depression, and anxiety. R4's Service Plan dated October 25, 2022, indicated R4 received services which included medication administration, dressing, grooming, bathing, brace assistance, housekeeping, and	0 630		

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0 630	Continued From page 10 laundry. R4's Individual Abuse Prevention Plan (IAPP) dated September 28, 2022, identified areas of vulnerability with interventions; however, lacked a review of R4's risk of abusing other vulnerable adults, and the potential risk of self-abuse. On November 8, 2022, at approximately 3:38 p.m., registered nurse (RN)-B reviewed R4's IAPP and confirmed R4's IAPP did not include assessment of R4's risk of abusing others or risk of self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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.	0 660		

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0 660	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include a fully developed TB plan. 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 November 7, 2022, at 10:35 a.m., the surveyor requested the licensee's facility TB risk assessment and TB plan, which was provided and later reviewed by the surveyor. The licensee's facility TB risk assessment had been completed by a registered nurse (RN) and was dated June 1, 2022. The facility had been identified as low risk. On November 7, 2022, at 4:12 p.m., RN-B reviewed the licensee's TB plan with the surveyor and confirmed the facility's TB plan did not include actions taken if a case of suspected or confirmed TB disease was identified among the licensee's staff or residents. The licensee's TB Screening, Prevention and	0 660		

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0 660	Continued From page 12 Control policy dated March 15, 2022, the facility would establish and maintain a TB prevention and control program based on the most current guidelines issued by CDC and Prevention. If a case of suspected or confirmed TB disease was identified among staff or residents, assure that appropriate actions are taken immediately. 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 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 13 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and post a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 November 7, 2022, at 11:25 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided to and later reviewed by the surveyor. On November 7, 2022, at 12:03 p.m., a facility tour was conducted with licensed assisted living director (LALD)-A. There was no observed signage posted or information regarding the licensee's EPP in the common areas of the facility. LALD-A stated the EPP binder could be found in each locked office. LALD-A stated the EPP was not posted in the common areas of the facility. The licensee's EPP provided to the surveyor	0 680		

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0 680	Continued From page 14 included a laminated Emergency Procedure Book with generic instructions which were not specific to the facility for staff to follow in the case of a fire, power outage, flood, tornado, hurricane, and earthquake. The EPP binder included an emergency staffing plan and some contact information for key staff and businesses providing services for the facility (electrical, telephone, natural gas). The licensee's EPP provided did not include the following: - a completed hazard vulnerability assessment (HVA) - policies and procedures to address natural and man-made disasters - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and	0 680		

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0 680	Continued From page 15 treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On November 8, 2022, at 10:01 a.m., registered nurse (RN)-B stated she was familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). After a brief review of the components required in an EPP by the surveyor, RN-B stated the facility's EPP had not been fully developed and they knew it was something they needed to work on completing. The licensee's Plans for Natural Disasters and Emergencies policy dated March 15, 2022, noted the director was responsible for the development of the facility's written plan of action to address the residents' care and services in response to a natural disaster or another type of emergency that may affect the facility's ability to provide services.	0 680		

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0 680	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 17 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required plans and drills for fire safety and evacuation. This had the potential to directly affect all residents 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) 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: On November 9, 2022, at approximately 11:15 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on November 9, 2022, between 11:15 a.m. and 11:45 a.m. 1. The fire safety and evacuation plans had not been developed for the facility location. Additionally, the plans did not include the identification of unique or unusual resident needs for movement or evacuation. The owner-(H) confirmed during the exit interview on November 9, 2022, at approximately 11:50 p.m., that the plans were a template from BeeHive Homes and had not been developed further. 2. The licensee did not meet the evacuation drill frequency requirements. Fire drill reports were provided, one was dated 11/01/2022 and the other reports were dated before 2019. The policies had the correct frequency for evacuation drills and the O-H explained that the licensee would be meeting the frequency requirements	0 810		

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0 810	Continued From page 18 moving forward. The O-H confirmed during the exit interview on November 9, 2022, at approximately 11:50 p.m., that there were times when evacuation drills had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 19 The findings include: During the entrance conference on November 7, 2022, at 11:25 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided to and later reviewed by the surveyor. The Residential Contract [assisted living contract] provided included a clause that indicted the resident would waive the facility's liability for health, safety, or personal property of the resident. On page 5, the section titled Damage or Injury to Resident, Guest(s) and Property, Acts of Third Parties and Renter's Insurance of the assisted living contract indicates management shall not be liable for any damage or losses to Resident or Resident's property, unless caused by the willful misconduct of Management. Management shall not be liable for personal injury to Resident or for damage to Resident's personal property caused by accidents or casualties, including but not limited to criminal acts, acts of nature, fire, bursting pipes, sewer or sewage backups, water, seepage, explosions, any casualty or other like causes. On November 8, 2022, at 9:07 a.m., owner (O)-H stated the licensee provided the same template assisted living contract to all residents. O-H stated it was a template contract developed by the corporate office and then the facility customized the contract to meet there needs. O-H reviewed the section on page 5 noted above and stated the contract language will need to be changed. No further information was provided.	0 970		

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0 970	Continued From page 20 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. (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 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 one unlicensed personnel (ULP)-F.	01440		

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01440	Continued From page 21 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 November 8, 2022, at 7:10 a.m., the surveyor observed ULP-F administer R3's scheduled morning medications. At 7:10 a.m., the surveyor observed ULP-F and ULP-G transfer R3 using a mechanical lift from a shower chair to R3's bed. ULP-F was hired on October 13, 2021, to provide direct care for the licensee's residents. ULP-F's employee record did not include documentation of a registered nurse (RN) supervising ULP-F performing a delegated task within 30 days of beginning work with the licensee. On November 9, 2022, at 9:21 a.m., RN-B stated the RN was responsible for conducting supervision within 30 days of a ULP's hire date. RN-B reviewed ULP-F's employee record and stated she was unable to find were ULP-F had had a 30-day supervision completed as required. The licensee's Supervision of Licensed and Unlicensed Staff policy dated March 15, 2022, noted 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	01440		

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01440	Continued From page 22 thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 23 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees (unlicensed personnel (ULP)-F, registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	01470		

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01470	Continued From page 24 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on October 13, 2021, to provide direct care for the licensee's residents. On November 8, 2022, at 7:10 a.m., the surveyor observed ULP-F administer R3's scheduled morning medications. At 7:10 a.m., the surveyor observed ULP-F and ULP-G transfer R3 using a mechanical lift from a shower chair to R3's bed. ULP-F's employee record did not include the following required orientation content: - an overview of the 144 G statutes - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person RN-B RN-B was hired on February 25, 2022, to provide direct care to the residents and supervise the staff. RN-B's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On November 9, 2022, at 9:33 a.m., RN-B reviewed ULP-F and her employee record and training transcript. RN-B stated ULP-F's assisted	01470		

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01470	Continued From page 25 living orientation had been completed prior to RN-B coming on board at the facility so she couldn't speak to her training but could see she had been trained on the home care statutes and not on the orientation required for assisted living facilities. RN-B was unsure if the licensee's online training program included a module focusing on person-centered planning. RN-B confirmed herself and ULP-F had not received the above orientation to assisted living as required. The licensee's Assisted Living Orientation policy dated March 15, 2022, noted all staff providing and supervising direct services must complete an orientation to assist [sic] living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must include the following topics [not an inclusive list]: - an overview of Minnesota's Assisted Living Law - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person, and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics	01540		

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01540	Continued From page 26 specified under paragraph (b) within 80 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 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 two of two employees (unlicensed personnel (ULP)-F, registered nurse (RN)-B) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on October 13, 2021, to provide direct care for the licensee's residents.	01540		

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01540	Continued From page 27 On November 8, 2022, at 7:10 a.m., the surveyor observed ULP-F administer R3's scheduled morning medications. At 7:10 a.m., the surveyor observed ULP-F and ULP-G transfer R3 using a mechanical lift from a shower chair to R3's bed. ULP-F's employee records did not indicate a total of 8 hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-F's employee record indicated the employee had completed 3.25 hours of dementia training. RN-B RN-B was hired on February 25, 2022, to provide direct care to the residents and supervise the staff. RN-B's employee records did not indicate a total of 8 hours of the required dementia training was completed within 80 hours of the employee's start date. RN-B's employee record indicated the employee had completed 2.25 hours of dementia training. On November 9, 2022, at 9:38 a.m., RN-B reviewed ULP-F and her employee record and training transcript. RN-B stated she had completed 2.25 hours of dementia training and ULP-F had completed 3.25 hours of dementia training. The licensee's Dementia Program Disclosure Requirements policy dated March 15, 2022, noted the licensee provided the required dementia training to all direct staff and their supervisors. No further information was provided.	01540		

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01540	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for one of three residents (R1) who received medication management. 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:	01750		

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01750	Continued From page 29 R1's diagnoses included history of a stroke, left sided hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body), chronic pain syndrome, high blood pressure, chronic obstructive pulmonary disease (COPD), pneumonia, and stage three (3) chronic kidney disease R1's prescriber orders dated November 2, 2022, included an order for ipratropium 0.5 milligrams (mg)/milliliters (ml) nebulizer solution to give one 3 ml jet via nebulizer three (3) times a day for shortness of breath. R1's service plan dated October 1, 2022, indicated R1 received medication management services. R1's November 2022, medication administration record (MAR) indicated ipratropium-albuterol (Duoneb) 3 mg/ 3 ml to administer Duoneb via nebulizer three times a day. R1's MAR lacked written directions for cleaning after use. On November 7, 2022, at 2:07 p.m., the surveyor observed unlicensed personnel (ULP)-K gather R1's single vial of ipratropium/albuterol solution, entered R1's room, put gloves on, fill the nebulizer cup with the nebulizer medication, assist putting the nebulizer mask on R1, turned on the nebulizer machine and told R1 ULP-K would be return in 10 minutes. ULP-K removed her gloves and left the room. At 2:27 p.m., ULP-K entered R1's room put on gloves, turned the nebulizer machine off, removed R1's nebulizer mask, disconnected the tubing from the nebulizer machine, went into R1's bathroom and in the bathroom sink, rinsed the nebulizer mask, vial, and tubing with water and placed the equipment	01750		

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01750	Continued From page 30 on a towel to dry. ULP-K stated the RN instructed her on how to clean the nebulizer after use all pieces of the equipment were to be rinsed including the tubing and place on a towel to dry. On November 8, 2022, at 11:32 a.m., ULP-C stated she was trained by RN-B in how to operate and clean R1's, nebulizer machine. ULP-C confirmed R1's record lacked a written procedure or instructions for operating and R1's nebulizer machine and rinsing the equipment after use. On November 8, 2022, at 3:47 p.m., RN-B stated R1's nebulizer treatment was new to staff, and she had been training staff one on one on administering the nebulizer treatment and aftercare. RN-B stated after each nebulizer use, staff were to disassemble the equipment, rinse the receptacle, and mask with water, and the tubing was not to be rinsed after use. The licensee's Nebulizer policy dated March 15, 2022, indicated once the treatment was completed, to disassemble parts, rinse out and leave on a clean paper towel to air dry until next use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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.	01880		

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01880	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures. 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 November 7, 2022, at 10:35 a.m., the registered nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents including medications storage. On November 7, 2022, at 11:43 a.m., the surveyor observed the medication refrigerators on Hive one and Hive two units with RN-B. Hive one's medication refrigerator had no medications being stored in the refrigerator at the time of the observation. Hive two's refrigerator contained resident eye drops along with cans of pop and nutritional shakes. RN-B stated the ULPs recorded the medication refrigerator temperatures daily in RTASKS (electronic documentation system). The surveyor requested three months of recorded temperatures to review which was later provided and reviewed.	01880		

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01880	Continued From page 32 Hive two's medication refrigerator temperature logs in RTAKS From August 1, 2022, through November 7, 2022, indicated the following: -August 1-31, 2022, contained 17 of possible 31 temperatures that were not recorded; -September 1-30, 2022, contained 13 of possible 30 temperatures that were not recorded; -October 1-31, 2022, contained seven (7) of possible 31 temperatures that were not recorded; and -November 1-17, 2022, contained two (2) of 7 possible temperatures that were not record. On November 7, 2022, at 3:02 p.m., RN-B confirmed the temperature logs provided had several dates where the log indicated the refrigerator was checked; however, temperatures were not documented. RN-B stated she called RTAKS and changed the system to where staff must enter a temperature daily as an assigned tasks. The surveyor observed Hive two's refrigerator with RN-B and verified the following medications were being stored: -two (2) unopened bottles of latanoprost ophthalmic 0.005% eye drops (used to treat increased pressure in the eye); and -one (1) unopened bottle of Xalantan 0.005% eye drop (used to treat increased pressure in the eye). The manufacturer's instructions for Xalantan (latanoprost ophthalmic solution) dated August 2011, indicated to store unopened bottle(s) under refrigeration between 36-46 degrees F. The licensee's Medication Storage policy dated March 15, 2022, indicated when secured storage of medications are necessary, the RN would identify where medications would be stored under	01880		

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01880	Continued From page 33 the proper temperature controls. 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; (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	01940		

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01940	Continued From page 34 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 three residents (R3) who had treatments managed by 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 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: During the entrance conference on November 7, 2022, at 11:08 a.m., registered nurse (RN)-B stated the licensee provided treatment and therapy services to residents. R3's diagnoses included dementia, low back pain, anxiety, and arthritis. R3's prescriber orders dated September 26, 2022, included an order for heel protectors (a medical device usually constructed of foam, gel, or fiber-filling, and is designed to offload pressure from the heel) to be applied bilaterally while in bed and may be used while resident is up in her chair instead of shoes to protect her heels. On November 7, 2022, at 1:09 p.m., the surveyor	01940		

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01940	Continued From page 35 observed unlicensed personnel (ULP)-C and ULP-E to transfer R3 with a mechanical lift from her chair to her bed. ULP-C provided incontinence cares, placed heel protectors on both of R3's heels, floated her heels on pillows and pulled R3's bed covers up so she could take a nap. R3's service plan dated August 3, 2022, lacked a written statement of the treatment services the resident received to include heel protectors. R3's record did not include evidence of an individualized treatment or therapy management plan which included the following: - a statement of the type of services that would be provided - identification of treatment or therapy tasks that would be delegated to ULP, and - procedures for notifying the RN or appropriate licensed health professional when a problem arises with treatments or therapy services. On November 8, 2022, at 3:57 p.m., RN-B stated heel protectors were not identified on R3's signed service plan. RN-B reviewed R3's treatment plan and medical record and confirmed R3's treatment plan for R3's heel protectors was incomplete. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks, dated March 15, 2022, noted when a treatment or therapy is delegated or assigned to ULP, the RN or authorized Licensed Health Professional must develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes. No further information was provided.	01940		

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01940	Continued From page 36 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating treatments, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the treatments for unlicensed personnel (ULP). In addition, the licensee failed to ensure specific written instructions for each resident were documented in one of three residents (R4) who received therapy or treatment	01950		

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01950	Continued From page 37 services. 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 November 7, 2022, at 10:35 a.m., RN-B confirmed the licensee provided treatment and therapy services. R4's diagnoses included late onset Alzheimer's dementia, osteoarthritis, stage three (3) chronic kidney disease, depression, and anxiety. R4's Service Plan dated October 25, 2022, indicated R4 received services which included medication administration, dressing, grooming, bathing, brace assistance, housekeeping, and laundry. R4's Individualized Treatment and Therapy Plan dated June 22, 2022, indicated applying and removal of R4's bilateral knee braces daily by ULP. R4's services delivered records dated October 1, 2022, through November 8, 2022, indicated the licensee assisted with putting on and taking off R4's knee braces. R4's treatment recap summary for October 2022, and November 2022, indicated R4 received assistance twice a day with R4's knee braces.	01950		

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01950	Continued From page 38 On November 7, 2022, at 1:10 p.m., the surveyor observed R4 sitting in her wheelchair with black external knee braces on both knees. On November 8, 2022, at 7:12 a.m., ULP-D stated R4 required assistance to apply and remove her knee braces daily. On November 9, 2022, at 8:12 a.m., RN-B stated R4 did not have written instructions for R4's knee braces for unlicensed staff in R4's record and further stated she was unable to find any instructions for R4's knee braces. RN-B stated R4 knew how to apply and remove the knee braces independently. RN-B stated the ULPs have not been trained by the RN in applying R4's knee braces and further stated R4 instructed staff in the proper way of applying R4's knee braces. On November 9, 2022, at 9:01 a.m., R4 stated staff assisted with applying and removing R4's knee braces daily. On November 9, 2022, at 9:04 a.m., ULP-I stated R4 required daily assistance with dressing including her knee braces. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks dated March 15,2022, indicated the RN may delegate nursing services to unlicensed staff only after the following: -completing a nursing assessment of the resident's functional status and need for nursing services; -developing a service plan for providing the services according to the resident's needs and preferences; -determining the unlicensed person is trained and	01950		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 39 competent and has been instructed in the proper methods to perform the procedures with respect to the specific resident; -include written instruction for performing the procedure for the resident in the resident's record; and -orientating the staff to the resident either in writing, in person or orally. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents and staff.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31350	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

(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
02040	Continued From page 40 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: On November 9, 2022, at approximately 11:15 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on November 9, 2022, between 11:15 a.m. and 11:45 a.m. A hazard vulnerability or safety risk assessment for hazards identified on and around the property was not included. The owner-(H) confirmed during the exit interview on November 9, 2022, at approximately 11:50 p.m., that this assessment had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

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	31350	A. BUILDING: _____ B. WING _____	11/09/2022

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02110	Continued From page 41 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives for three of three residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02110		

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BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

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02110	Continued From page 42	02110		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The facility currently held an Assisted Living with Dementia Care license.

On November 7, 2022, at 11:25 a.m., during the entrance conference, the surveyor asked for the licensee's assisted living with dementia care policies and procedures. The Care Disclosure for Alzheimer's Disease and Other Dementias policy provided did not include the following:
- evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed
- wandering and egress prevention that provides detailed instructions to staff in the event of a resident elopes
- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications
- limiting the use of public address and intercom systems for emergencies and evacuation drills only
- transportation coordination and assistance to and from outside medical appointments; and
- safekeeping of residents' possessions

R1
R1's diagnoses included history of a stroke, left sided hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one

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	31350	A. BUILDING: _____ B. WING _____	11/09/2022

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BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

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02110	Continued From page 43 side of the body), chronic pain syndrome, high blood pressure, chronic obstructive pulmonary disease (COPD), pneumonia, and stage three (3) chronic kidney disease. R1's representative signed an acknowledgement form dated December 16, 2021, that she had received the Care Disclosure for Alzheimer's Disease and Other Dementia's policy noted above. R3 R3's diagnoses included dementia, low back pain, anxiety, and arthritis. R3's representative signed an acknowledgement form dated August 1, 2020, that he had received the Care Disclosure for Alzheimer's Disease and Other Dementia's policy noted above. R4 R4's diagnoses included late onset Alzheimer's dementia, osteoarthritis, stage three (3) chronic kidney disease, depression, and anxiety. R4's representative signed an acknowledgement form dated June 17, 2022, that she had received the Care Disclosure for Alzheimer's Disease and Other Dementia's policy noted above. On November 9, 2022, at 3:40 p.m., registered nurse (RN)-B stated the only dementia care policy that is provided to the resident and/or their representative was the Care Disclosure for Alzheimer's Disease and Other Dementias noted above. After a brief review of the dementia care policies required RN-B stated it would be an easy fix to add the required policy information. No further information was provided.	02110		

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02110	Continued From page 44 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (registered nurse (RN)-B), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	02140		

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02140	Continued From page 45 The facility was licensed as an assisted living facility with dementia care. During the entrance conference on November 7, 2022, at 10:43 a.m., RN-B stated she was in charge of overseeing the dementia care training for staff. RN-B's employee record indicated she had completed 2.25 hours of dementia care training since her hire date of February 25, 2022. RN-B's record lacked evidence of demonstrated competency to be the person in charge of overseeing staff training for dementia care. On November 9, 2022, at 9:42 a.m., RN-B stated she did not have a training certificate to verify knowledge and demonstrate competency related to dementia care. RN-B stated she was unaware of this requirement. The licensee's Dementia Program Disclosure Requirements policy dated March 15, 2022, noted the licensee provided the required dementia training to all direct staff and their supervisors. The policy did not address the requirements of the person(s) providing or overseeing staff training for assisted living facilities with dementia care. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

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02170	Continued From page 46 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a comprehensive	02170		

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02170	Continued From page 47 evaluation for activities and an individual activity plan (IAP) for three of three residents (R1, R3, R4) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1 R1's diagnoses included history of a stroke, left sided hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body), chronic pain syndrome, high blood pressure, chronic obstructive pulmonary disease (COPD), pneumonia, and stage three (3) chronic kidney disease. R1's Individual Activity Plan dated September 22, 2022, indicated R1 was poorly motivated to participate in activities, exhibited signs of loneliness, and had physical limitations. R1's IAP lacked the following required content: - current abilities and skills; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 48 R3 R3's diagnoses included dementia, low back pain, anxiety, and arthritis. R3's IAP dated October 11, 2022, indicated R3 was mostly nonverbal and unable to ambulate, and staff does bring R3 to activities for her to be in the company of others. R3's IAP lacked the following required content: - emotional and social needs and patterns; and - adaptations necessary for the resident to participate R4 R4's diagnoses included late onset Alzheimer's dementia, osteoarthritis, stage three (3) chronic kidney disease, depression, and anxiety. R4's Individual Activity Plan dated September 28, 2022, lacked the following required content: - past and current interests; and - current abilities and skills. In addition, R1, R3, and R4's records lacked the development of an individualized activity plan based on the activity evaluation. On November 8, 2022, at 3:47 p.m., registered nurse (RN)-B stated activity evaluations should be individualized for each resident and confirmed the licensee's current IAP activity evaluations being used for residents did not address all the required content noted above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *11/08/22*
Time: 10:30:00
Report: 1016221187

Food and Beverage Establishment Inspection Report

Location:
Beehive Assisted Living - Main Kitchen
4014 Trinity Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0030954
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
Northern Lives Inc.

Phone #: 2187224014
ID #: 42277

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.

DENISE HAS A SERVSAFE CERTIFICATE BUT NO CFPM CERTIFICATE. POST CFPM.

Comply By: 11/30/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = 164 at Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 188 Degrees Fahrenheit - Location: CHILI
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: PASTA SALAD
Violation Issued: No

Type: Full
Date: *11/08/22*
Time: 10:30:00
Report: 1016221187

Food and Beverage Establishment Inspection Report

Beehive Assisted Living - Main Kitchen

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: STRAWBERRIES
Violation Issued: No

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

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM. CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 1016221187 of 11/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Denise Austin
Kitchen Manager

Signed:_____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us