DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 11, 2023

Licensee
Berkeley Heights Homes LLC
1808 Meadowwood Court
Brooklyn Park, MN 55444

RE: Project Number(s) SL36469015

Dear Licensee:

On April 25, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 23, 2022, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Electronically Delivered

March 15, 2023

Licensee
Berkeley Heights Homes LLC
1808 Meadowwood Court
Brooklyn Park, MN 55444

RE: Project Number(s) SL36469015

Dear Licensee:

On February 13, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 23, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the November 23, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 23, 2022, found not corrected at the time of the February 13, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 13, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36469	A. BUILDING: _____ B. WING _____	R 02/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL36469015-1 On February 10, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 23, 2022. At the time of the survey, there were two residents receiving services under the Assisted Living license. As a result of the revisit, the following correction orders were reissued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 470} 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: No further action required	{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,	{0 480}		

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{0 485} SS=F	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required	{0 485}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services	{0 490}		

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{0 490}	Continued From page 3 appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required	{0 490}		
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	{0 630}		

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{0 630}	Continued From page 4 by: No further action required	{0 630}		
{0 660} SS=D	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: No further action required	{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;	{0 680}		

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{0 680}	Continued From page 5 (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: No further action required	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	{0 780}		

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{0 780}	Continued From page 6 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required	{0 780}		
{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 Code; and This MN Requirement is not met as evidenced by: No further action required	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 7 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the home in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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, 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 are: On February 13, 2023, approximately from 11:25 a.m. to 12:10 p.m. survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed and the LALD-C verified the following: RESIDENT ROOM #4 (Lower Level) At approximately noon, survey staff asked the LALD-C about the entrance to resident room #4 located on the lower-level floor. The LALD-C explained that the resident stated that she was ill	{0 800}		

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{0 800}	Continued From page 8	{0 800}		

and declined entry by anyone. Survey staff explained the findings from the last survey (November 22, 2022) for resident room #4 will remain as noted if survey staff was not able to enter to verify if the findings have been addressed:

-The resident room #4 was cluttered, stacked, and packed throughout on the floor and counters with excessive clothing, household items, and furniture restricting a path or means to properly move safely inside the bedroom to the door in case of an emergency for safe egress.
-The egress window was obstructed by cabinet and personal items to the windowsill height obstructing the proper use of the egress window for immediate use during an emergency ready access.

At approximately 12:05 p.m., the LALD-C explained that the licensee had not been successful at addressing the clutter and cleaning the resident's room but had been able to replace the flooring in the room.

CARPET FLOORING
-The carpet flooring inside the upper-level resident rooms #1 and #2 was soiled and had dirty stains.
- The carpet flooring of the stairway between the two levels was heavily soiled and stained throughout.

On February 13, 2023, at approximately 12:30 p.m., during the exit interview, the LALD-C acknowledged the above findings. The LALD-C explained that they have started the conversation with their handyman about replacing the carpet flooring in resident rooms #1 and #2, and will be taken care of soon. Survey staff asked for

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{0 800}	Continued From page 9 documentation to show a timeline that it will be addressed and the LALD-C stated in about a month, but the LALD-C lacked documentation to substantiate the proposed work schedule. No further information was provided.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	{0 810}		

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{0 810}	Continued From page 10 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide accurate content on the fire safety and evacuation plan, required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 13, 2023, at approximately 12:20 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation and related documentation from the licensed assisted living director (LALD)-C. Document review and interview with the LALD-C at 12:30 p.m. indicated the following: 1. The posted floor layout plan near the stairs incorrectly labeled the patio door as an exit when the patio door was secured from opening since no deck on the upper level. Survey staff and the LALD-C walked to the posted evacuation floor	{0 810}		

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{0 810}	Continued From page 11 plan layout and went over the exit routes and survey staff explained to the LALD-C of the noncompliance. The LALD-C confirmed the finding. 2. Document review showed the licensee failed to meet the minimum required frequency twice per year (after orientation) for employee training on the fire safety and evacuation plan for the home. Employee training record review indicated one annual employee training on fire safety and evacuation was provided to employees in 2022 rather than twice per year. 3. The review of the drill documentation indicated licensee failed to document the time and/or shifts the employee fire drills were performed to determine compliance with the minimum number of required employee fire and evacuation drills of a minimum of two drills per year per shift with at least one drill every other month. Fire drill records received and reviewed were dated 12/20/2022 (no time) and 1/15/2023 (no time). Survey staff also explained to the LALD-C that the records did not show evacuation information and that evacuation drills must also be included in the fire drills. On February 13, 2023, at approximately 1:00 p.m., during the exit interview, the LALD-C acknowledged the above findings and requested that he submitted additional training documentation to survey staff by end of the day. Additional documentation was received via email on Monday 02/13/2023 at 7:28 PM from the LALD-C, including resident fire protection procedures (undated), a record of annual resident training on fire and evacuation, dated 12/17/2022 12:30 p.m., and record of employee annual fire and evacuation training dated 12/5/2022.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36469	A. BUILDING: _____ B. WING _____	R 02/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

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{0 900}	Continued From page 12	{0 900}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action required	{0 900}		

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{0 910}	Continued From page 13	{0 910}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action required	{0 910}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay	{0 940}		

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{0 940}	Continued From page 14 privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required	{0 940}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required	{0 970}		

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

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{01060}	Continued From page 16 refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required	{01060}		
{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 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: No further action required	{01620}		

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{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required	{01650}		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup,	{01770}		

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{01770}	Continued From page 18 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. This MN Requirement is not met as evidenced by: No further action required	{01770}		
{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: No further action required	{01910}		
{02330} SS=D	144G.91 Subd. 5 Refusal of care or services	{02330}		

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{02330}	Continued From page 19 Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services. This MN Requirement is not met as evidenced by: No further action required	{02330}		

Electronically Delivered

December 29, 2022

Licensee
Berkeley Heights Homes, LLC
1808 Meadowwood Court
Brooklyn Park, MN 55444

RE: Project Number(s) SL36469015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 23, 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.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

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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: SL36469015 On November 21, 2022, to November 23, 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 three active residents receiving services under the Assisted Living license. The immediacy of immediate correction order(s) tag identification 2310, identified on November 23, 2022 has not been removed as of exit.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for 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 and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents and an evaluation conducted at least twice a year to determine appropriateness of staffing levels in the facility. In addition, the licensee failed to ensure the required 24-hour staffing schedule was posted in a central location.	0 470		

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0 470	Continued From page 2 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 21, 2022, at 9:30 a.m., during the entrance conference attended by registered nurse (RN)-A and licensed assisted living director (LALD)-C, the surveyor requested the licensee's staffing plan. On November 21, 2022, at 10:30 a.m., during the facility tour, the surveyor did not observe a posted 24-hour staffing schedule in any of the licensee's communication boards. The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On November 21, 2022, at 10:45 a.m., RN-A verified the licensee had not developed and implemented a staffing plan for determining its staffing level and did not have a posted 24-hour staffing schedule in a central location.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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	0 480		

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0 480	Continued From page 4 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 22, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all three residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 21, 2022, at 10:30 a.m., the surveyor observed the menu plan on the bulletin board. The observed menu was not prepared at least one week in advance and lacked dates of the week. On November 21, 2022, at approximately 10:45 a.m., registered nurse (RN)-A stated the menu was made available to residents by use of the bulletin board. RN-A stated the menu plan on the bulletin board was what residents had available. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 6 (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all the residents of the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 490		

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0 490	Continued From page 7 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 November 21, 2022, at 9:50 a.m., during the entrance conference, the surveyor requested to see the licensee's daily program of social and recreational activities. On November 21, 2022, at 12:15 p.m., the surveyor did not observe any activities were planned or offered to the residents. Residents remained in their rooms most of the day, and some paced back and forth to the kitchen, outside, and to their rooms. On November 22, 2022, at 12:05 p.m., registered nurse (RN)-A verified the licensee did not have a daily program of social and recreational activities, and stated residents are kept busy with some activities, though they did not have a daily activity program developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 8 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 statements of the specific measures to be taken to minimize the risk of abuse for two of three residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee July 7, 2022, with the following diagnoses: paranoid type, antisocial personality traits, and schizophrenia. R1's record included an Individual Abuse Prevention Assessment dated July 21, 2022, indicating R1 had the following vulnerabilities: elopement risk, risk of abusing other vulnerable adults, alcohol/chemical and/or medication abuse, chronic condition, and risk of self-abuse.	0 630		

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0 630	Continued From page 9 The IAPP lacked specific measures to be taken by licensee to minimize the risk of abuse identified in the plan. R4 R4 was admitted to the licensee January 5, 2022, with the following diagnoses: major depressive disorder, high blood pressure, arthritis, and multiple sclerosis. R4's record included an Individual Abuse Prevention Assessment dated January 5, 2022, indicating R1 had the following vulnerabilities: chronic condition, verbally abusive, chemical and/or other medication abuse. The IAPP lacked specific measures to be taken by licensee to minimize the risk of abuse identified in the plan. On November 22, 2022, at 12:25 p.m., registered nurse (RN)-A verified the IAPPs lacked specific measures to be taken by the licensee to minimize risk of abuse identified for each resident. RN-A stated the IAPP forms lacked interventions individualized for each resident and the same forms were used for all residents. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	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	0 660		

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0 660	Continued From page 10 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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The facility's TB risk assessment dated August 1, 2021, indicated the facility was a low risk setting for TB transmission. ULP-E was hired on June 10, 2022, and provided direct care for residents of the licensee.	0 660		

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0 660	Continued From page 11 ULP-E's employee record included a partially completed TB history and symptom screening form (which did not have a reviewer) dated April 15, 2022, but lacked documentation of TB baseline screening test results. On November 22, 2022, at 9:39 a.m., registered nurse (RN)-A stated ULP-E had a positive TB skin test prior to her hire date and a negative chest x-ray. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated "Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.	0 660		

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0 660	Continued From page 12 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." 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 working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. 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's EPP lacked the following content: - a communication plan that included: 1) arrangement with other facilities; 2) names and contact information for staff, resident physicians, and other facilities; and 3) contact information for federal, state, tribal, and ombudsman. - Subsistence needs for staff and patients; - Procedures for tracking of staff and patients; - Policies and procedures including evacuation; - Policies and procedures for sheltering; - Policies and procedures for medical documents; - Policies and procedures for volunteers; - Sharing information on occupancy/needs; - LTC family notifications; - Emergency prep training and testing; - Emergency prep training program; and - Emergency prep testing requirements.	0 680		

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0 680	Continued From page 14 On November 22, 2022, at 1:40 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged the EPP lacked the required content. LALD-C stated the licensee was working with sister facilities to upgrade their EPPs to include all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a properly installed smoke alarm inside the lower-level resident room #4 and interconnection of the smoke alarm in the hallway within the vicinity of the resident rooms on the upper-level floor with other smoke alarms in the home. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 22, 2022, approximately from 12:30 p.m. to 2:30 p.m. survey staff toured the home with the licensed assisted living director (LALD)-C from 12:30 p.m. to 12:45 p.m. and with the unlicensed personnel (ULP)-F for the remaining of the tour. During the tour, survey staff observed and the ULP-F verified the following: 1) The smoke alarm located outside within the vicinity of the upper-level floor resident rooms #1 and #2 was not interconnected with the home's smoke alarm when tested by the ULP-F. The finding was evident when the smoke alarm was tested by the ULP-F and it only sounded local and did not sound any other alarms in the home. 2) The smoke alarm inside the lower-level	0 780		

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0 780	Continued From page 16 resident room #4 was observed to have exposed wires hanging loosely around 18 inches below the ceiling. In addition, the ceiling tiles where the smoke alarm wires were hanging from were damaged and therefore, unable to secure the smoke alarm. On November 22, 2022, at approximately 3:00 p.m., during the exit interview, the LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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 Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly	0 790		

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	36469	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

(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
0 790	Continued From page 17 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). On November 22, 2022, approximately from 12:30 p.m. to 2:30 p.m. survey staff toured the home with the licensed assisted living director (LALD)-C from 12:30 p.m. to 12:45 p.m. and with the unlicensed personnel (ULP)-F for the remaining of the tour. During the tour, survey staff observed and the ULP-F verified the following: 1) The portable fire extinguishers were tagged with monthly inspections for years 2021 and 2022 but lacked records to show the required annual service date on both portable fire extinguishers. 2) The portable fire extinguisher was located inside the mechanical room on the lower-level floor, and not easily visible. In addition, the portable fire extinguisher was not mounted and secured as it fell on the floor when the tag was under review by survey staff. On November 22, 2022, at approximately 3:00 p.m., during the exit interview, the LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		

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0 800	Continued From page 18	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the home in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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, 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 are: On November 22, 2022, approximately from 12:30 p.m. to 2:30 p.m. survey staff toured the home with the licensed assisted living director (LALD)-C from 12:30 p.m. to 12:45 p.m. and with the unlicensed personnel (ULP)-F for the remaining of the tour. During the tour, survey staff observed and the ULP-F verified the following:	0 800		

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0 800	Continued From page 19 1) RESIDENT ROOM #4 (Lower Level) On November 22, 2022, at approximately 1:00 p.m., survey staff and the ULP-F seek permission from the resident to enter room #4 located on the lower-level floor, but the resident declined entry and appeared to sound upset and did not open the door. At approximately 1:15 p.m., survey staff and the ULP-F observed the door to bedroom #4 was partially opened with the resident cleaning inside. Based on the door being partially opened, survey staff observed the following: -The resident room #4 was cluttered, stacked, and packed throughout on the floor and counters with excessive clothing, household items, and furniture restricting a path or means to properly move safely inside the bedroom to the door in case of an emergency for safe egress. -The egress window was obstructed by cabinet and personal items to the windowsill height obstructing the proper use of the egress window for immediate use during an emergency ready access. -The doorknob hardware was loose and not secure to the door. 2) RESIDENT ROOM #5 (Lower Level) The ULP-F made multiple attempts using their master keys to open the door to the lower-level resident room #5, but the ULP-F failed to open the door for the requested entry. The ULP-F commented that the resident would have the key but currently not home. No entry was possible at the time of the home tour but survey staff observed the following on the outside of the door: - The door (hollow type) was significantly damaged with large cracks. -The door had a padlock but was missing a doorknob hardware set for proper exiting. -The molding and trim were missing from the	0 800		

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0 800	Continued From page 20 door frame. This was evident as there were visible gaps around the door frame. These gaps would prevent smoke-tight protection during a fire. 3) CARPET FLOORING -The carpet flooring inside the lower-level resident room #3 was heavily soiled with dark stains on the carpet. -The carpet flooring inside the upper-level resident rooms #1 and #2 was soiled and dirty stains. The carper flooring inside the lower-level floor of resident room #4 (where visible) was heavily soiled and stained. - The carpet flooring of the stairway between the two levels was heavily soiled and stained throughout. -The carpet flooring on the lower-level common areas and hallways were heavily soiled and stained. 4) BATHROOM -One of the sliding doors for the shower was not operable in the lower-level bathroom. On November 22, 2022, at approximately 3:00 p.m., during the exit interview, the LALD-C acknowledged the above findings. The LALD-C explained that they have residents that would not allow anyone to clean their room. In addition, the LALD-C stated that the door to resident room #5 (lower-level) had been damaged by the resident multiple times and they have replaced the door three or four times already. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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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 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all	0 810		

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0 810	Continued From page 22	0 810		

required content on the fire safety and evacuation plan, required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 22, 2022, at approximately 2:35 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation and related documentation from the licensed assisted living director (LALD)-C. Document review indicated the following:

1) The posted floor layout plan incorrectly labeled the patio door as an exit when the patio door was secured from opening since no deck existed on the upper level.
2) The fire safety and evacuation plan documentation lacked fire protection procedures for residents.
3) Documentation review showed the licensee lacked a record of employee training on the fire safety and evacuation plan for the home. Employee training record was requested but no record was provided for review. The LALD-C stated that he has training records and will send them via email. Survey staff stated that the training records will be honored if received by end

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0 810	Continued From page 23 of the day. 4) Documentation review indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. Resident training record for fire safety and evacuation was requested but was not provided for review. 5) The review of the drill documentation indicated licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The documentation showed quarterly drills performed to date. On November 22, 2022, at approximately 3:00 p.m., during the exit interview, the LALD-C acknowledged the above findings. Additional documentation was received via email on November 22, 2022, at 6:34 p.m. from the LALD-C, undated PowerPoint, "Emergency Preparedness Training" consisting of nine slides. No documented records of employee training were received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 24 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a	0 900		

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0 900	Continued From page 25 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 finding include: R1 was admitted to the facility on July 7, 2022, with diagnoses including paranoid type, antisocial personality traits, and schizophrenia. R1's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed by R1 July 7, 2022. The document included a section to be signed and dated by the licensee's representative but did not sign and only printed the facility name instead. On November 22, 2022, licensed assisted living director (LALD)-C said the document was the contract between R1 and licensee. LALD-C also said the licensee section had not been signed and dated to complete the contract as required. LALD-C further stated all resident contracts are considered complete and binding when both the licensee and resident or resident representative have signed it. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information	0 910		

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0 910	Continued From page 26 (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee July 7, 2022. R1's Service Plan dated July 7, 2022, indicated R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares.	0 910		

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0 910	Continued From page 27 R1's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed July 7, 2022. R4 was admitted to the licensee January 5, 2022. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. R4's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed January 5, 2022. R1 and R4's contracts were lacking the health facility identification number (HFID) for the licensee. On November 22, 2022, at 3:42 p.m., licensed assisted living director (LALD)-C verified R1 and R4's contracts were lacking required content. LALD-C stated the same contract was used for all the licensee's residents and needed to be updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide	0 940		

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0 940	Continued From page 28 customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 940		

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0 940	Continued From page 29 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated July 7, 2022, indicated R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares. R1's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed July 7, 2022. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including: medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. R4's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed January 5, 2022. R1 and R4's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (B); -whether there is a limit on the number of people	0 940		

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0 940	Continued From page 30 residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On November 22, 2022, at 11:52 a.m., licensed assisted living director (LALD)-C acknowledged the inconsistencies in the contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that LALD-C may not have access to. LALD-C also stated the same contract was used for all the licensees' residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
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	0 970		

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0 970	Continued From page 31	0 970		

include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of two residents (R1, R4).

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1 was admitted to the licensee July 7, 2022. R1's Service Plan dated July 7, 2022, indicated R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares.

R1's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed July 7, 2022.

R4's Service Plan dated January 5, 2022,

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0 970	Continued From page 32 indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. R4's record included a Resident Agreement Assisted Living Summary of Important Terms document dated and signed January 5, 2022. R1 and R4's Residency Agreement Assisted Living Summary of Important Terms document included clauses under miscellaneous provisions section that indicated the owner was not liable to resident for any injury, death or property damage occurring in the apartment or on owner's premises unless such injury, death or property damage occurred as the result of an equipment malfunction or hazardous conditions within the building not caused by resident. On November 21, 2022, at 11:50 a.m., licensed assisted living director (LALD)-C stated all the licensee's resident agreements was the same and contained liability waiver language as indicated above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 33 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure a notice with required content was provided to the resident/representative for	01060		

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01060	Continued From page 34 one of two residents (R2) who had an emergency relocation out 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 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: R2 was admitted to licensee August 15, 2022, with diagnoses to include schizophrenia, cannabis abuse, intellectual functioning, and suicidal ideation. R2's Service Plan dated August 15, 2022, indicated R2 was receiving services to include medication management services, housekeeping, linen change, "I'm ok" checks, and personal laundry. R2's record included a hospital discharge summary indicating R2 was admitted to the hospital from October 5, 2022, through October 19, 2022, for a total of 15 days. R2's record lacked evidence a written emergency relocation notice was provided to the resident and resident's representative that at minimum contained: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date	01060		

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01060	Continued From page 35 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On November 22, 2022, at 4:25 p.m., registered nurse (RN)-A verified R2 was admitted to hospital on the dates identified above but no emergency relocation notice was completed. RN-A stated the licensee was aware of the requirement to complete an emergency relocation notice, but had not completed one for any of the licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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	01620		

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01620	Continued From page 36	01620		

completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) used a uniform assessment tool to conduct ongoing client monitoring and reassessments for two of two residents (R1, R4). In addition, the licensee failed to ensure the RN conducted ongoing resident monitoring and reassessments not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1 was admitted to the licensee July 7, 2022. R1's Service Plan dated July 7, 2022, indicated

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01620	Continued From page 37 R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares. R1's record included an initial nursing assessment Uniform Assessment Tool completed July 7, 2022. R1's record included a 14-day assessment Ongoing Monitoring and Reassessment document dated July 21, 2022. R1's record included a 90-day assessment Ongoing Monitoring and Reassessment document dated October 12, 2022, which exceeded 90 calendar days from the last date of the last assessment. R4 R4 was admitted to the licensee January 5, 2022. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. R4's record included an initial nursing assessment Uniform Assessment Tool completed January 5, 2022. R4's 14-day assessment was completed on January 21, 2022. R4's record included a 90-day assessment Ongoing Monitoring and Reassessment document dated April 5, 2022. No further assessments were documented in R4's chart. R1 and R4's 14-day, and 90-day assessments were not completed on the required uniform assessment tool with all required sections to include: - the resident's personal lifestyle preferences; - activities of daily living, including;	01620		

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01620	Continued From page 38 - instrumental activities of daily living, including; - physical health status, including; - emotional and mental health conditions; - cognition; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs; - risk indicators; and - who has decision-making authority for the resident. On November 22, 2022, at 11:28 a.m. RN-A verified R1 and R4's ongoing assessments did not include all the sections of the uniform assessment tool. Also, RN-A verified R1's 90-day assessment exceeded 90 calendar days from the last date of the assessment, and R4 lacked ongoing nursing assessments not to exceed 90 calendar days from the last date of the assessment. RN-A stated the previous RN was not completing the ongoing resident assessments on schedule and so RN-A was playing catch-up and will soon be caught up. RN-A also verified the Ongoing Monitoring and Reassessment document lacked the sections of the uniform assessment tool as required. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days from the last date of assessment. No further information was provided.	01620		

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01620	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01650		

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01650	Continued From page 40 licensee failed to ensure the service plan included all required content for four of four residents (R1, R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee July 7, 2022. R1's Service Plan dated July 7, 2022, indicated R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares. R2 R2 was admitted to licensee August 15, 2022. R2's Service Plan dated August 15, 2022, indicated R2 was receiving services to include medication management services, housekeeping, linen change, "I'm ok" checks, and personal laundry. R4 R4 was admitted to the licensee January 5, 2022. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change.	01650		

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01650	Continued From page 41 R5 R5 was admitted to the licensee November 5, 2021. R5's Service Plan dated October 26, 2022, indicated R5 was receiving services including medication management, meal preparation, personal laundry, and behavior management. R5's service plan lacked the content to include: the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition. R1, R2, R4, and R5's service plan lacked the content to include: - the fees for services. On November 21, 2022, at 3:40 p.m., licensed assisted living director (LALD)-C verified R1, R2, R4, and R5's service plan lacked required content. LALD-C also stated the same service plan was used for all the licensee residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
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. This MN Requirement is not met as evidenced	01770		

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01770	Continued From page 42 by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 21, 2022, at 9:40 a.m., registered nurse (RN)-A stated the licensee provided medication management services which included medication setup by the RN for their residents. R1's Service Plan dated July 7, 2022, indicated R1 was receiving the following services: medication administration, housekeeping, personal laundry, "I'm ok" checks, treatment/therapies, meal preparation, and assistance with personal cares. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. On November 22, 2022, at 8:10 a.m., and 8:20 a.m., unlicensed personnel (ULP)-E dispensed medications to R1 and R4 from their respective	01770		

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01770	Continued From page 43 pill boxes. On November 22, 2022, at 3:40 p.m., the RN-A provided the surveyor with a Medication Set-up Dates record with weekly dates running from August 29, 2022, through November 21, 2022. Against each weekly date was indicated "completed" signifying for that week all resident medications were set-up. R1 and R4's record lacked documentation by the RN at the time of medication setup to include documentation of the name of the medication, quantity of dose, times to be administered, route of administration, and the name of the person completing medication setup. On November 22, 2022, at 4:30 p.m., RN-A, verified all resident medication set-ups are completed weekly for all the licensee's residents and documented in Medication Set-up Dates record as "completed". RN-A also acknowledged the required content identified above was missing in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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	01910		

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01910	Continued From page 44 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 provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (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, 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: R3 was admitted to licensee September 30, 2021, and was discharged November 30, 2021.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36469	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

(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
01910	Continued From page 45 R3's undated service plan indicated R3 was receiving services to include medication management, housekeeping, and linen change. R3's record lacked documentation of the disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On November 22, 2022, at 1:43 p.m., registered nurse (RN)-A stated R3's medication disposition documention was missing. RN-A also stated that R3 was discharged by another RN who no longer works for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards	02310		

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	36469	A. BUILDING: _____ B. WING _____	11/23/2022

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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
02310	Continued From page 46 with regards to smoking safety, for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: State of Minnesota statute 144.414 Prohibitions dated 2022, indicated in Subdivision 3 Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. R1 was admitted for service July 7, 2022, with the following diagnoses: paranoid personality disorder (PPD) (mental illness characterized by paranoid delusions, and a pervasive, long-standing suspiciousness and generalized mistrust of others), antisocial personality traits, and schizophrenia (a serious mental disorder in which people interpret reality abnormally). R1's service plan dated July 7, 2022, indicated R1 received assistance with the following services: assistance with dressing, self-feeding,	02310		

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	36469	A. BUILDING: _____ B. WING _____	11/23/2022

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BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

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02310	Continued From page 47	02310		

oral hygiene, housekeeping and linen change, grooming, hair care, bathing, laundry, medication administration, treatment/therapies, eating assistance, and "I'm okay" checks daily.

R1's Uniform Assessment Tool dated July 7, 2022, indicated R1 was a smoker, and R1 understood and could locate designated smoking area. The assessment also indicated R1could handle smoking materials appropriately; R1 was independent and smoking materials were locked at the nurse station.

R1's Individual Abuse Prevention Assessment dated July 12, 2022, indicated R1 smoked tobacco and the intervention included staff to report any use of alcohol or chemicals used by R1 to the nurse promptly. The assessment lacked interventions to ensure safe smoking.

During an interview with R1 on November 21, 2022, at 11:35 a.m., the surveyor requested to know if R1 was a smoker and if he had been shown a designated smoking area. R1 stated he smoked and stated sometimes he smoked in his room, but he had not been caught.

On November 21, 2022, at 12:40 p.m., licensed assisted living director (LALD)-C stated R1 was a one on one because R1 was at risk of elopement. At 1:30 p.m., unlicensed personnel (ULP)-B confirmed she was working one on one with R1 to ensure he was safe.

On November 22, 2022, at 8:10 a.m., the surveyor observed ULP-E administer morning medications to R1 and later served him a cheese sandwich for breakfast.

On November 22, 2022, at 10:20 a.m., the

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	36469	A. BUILDING: _____ B. WING _____	11/23/2022

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BERKELEY HEIGHTS HOMES LLC	1808 MEADOWWOOD COURT BROOKLYN PARK, MN 55444

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02310	Continued From page 48	02310		

surveyor, in the presence of the registered nurse (RN)-A, observed R1 buy cigarettes from R4. R1 handed R4 four quarters in exchange for three cigarettes. When RN-A intervened to understand what the residents were doing, R4 said she was only giving R1 cigarettes because R1 did not have any money to buy them.

On November 22, 2022, at 11:00 a.m., the surveyor and LALD-C requested to enter R1's room, but R1 declined stating he was sleeping and did not want anyone to disturb him.

On November 22, at 11:20 a.m., the surveyor, LALD-C, and RN-A smelled cigarette smoke in the lower level of the building where R1's bedroom was located. LALD-C called out to R1 to inquire if he was smoking in his room, but R1 declined and would not open his door when he was requested.

On November 22, at 2:25 p.m., the engineering surveyor and ULP-F entered R1's room during the engineer's facility tour. The engineering surveyor confirmed the room smelled like cigarette smoke. The engineering surveyor asked ULP-F and he confirmed it smelled like smoke and stated sometimes R1 smoked in his room.

On November 23, 2022, at 11:12 a.m., LALD-C sent the surveyor an email with pictures of R1's room. On the pictures, the surveyor observed what looked like cigarette butts on the floor, burns marks on the carpet, and ashes on the mattress.

On November 23, at 12:09 p.m., LALD-C stated there were no cigarette butts on the floor except the room is dirty with "a lot of stuff." LALD-C also stated the stains on the mattress are spills from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 49 drinks like soda, coffee, and some blood stains. When asked why the room was dirty, LALD-C stated the room was dirty because R1 would not allow anyone to clean the room. The licensee's Residents' Smoking in Designated Areas policy dated August 1, 2021, indicated the prohibition of smoking cigarettes and other tobacco related paraphrenia that requires the use of matches and lighters in all residents' rooms. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02330 SS=D	144G.91 Subd. 5 Refusal of care or services Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to document any efforts to educate a resident who was repeatedly refusing a medication ordered by a prescriber for one of one resident (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).	02330		

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02330	Continued From page 50 The findings include: R4 was admitted to the licensee January 5, 2022. R4's Service Plan dated January 5, 2022, indicated R4 was receiving services including medication administration, housekeeping, personal laundry, "I'm ok" checks, meal preparation, and linen change. R4's physician orders dated November 11, 2022, indicated R4 was taking medication to include amlodipine 10 milligram (mg) take one tablet by mouth once daily, fluticasone nasal 50 microgram (mcg)/spray use two spray in each nostril once daily, fluoxetine capsule 20 mg take one capsule by mouth once daily, indomethacin capsule 25 mg take one capsule by mouth twice daily with meals, propranolol tablet 10 mg take one tablet by mouth twice daily, gabapentin tablet 600 mg take two tablets by mouth three times daily, and tizanidine 2 mg tablet take one tablet by mouth every evening. On November 22, 2022, at 8:10 a.m., unlicensed personnel (ULP)-E administered morning medications to R4 from the pill box. The surveyor observed R4 pick out one medication from the medication cup and told ULP-E the medication made R4 sleepy. On November 22, 2022, at 8:25 a.m., ULP-E stated R4 always picked out this medication and never took it. ULP-E also stated she did not document the occurrence but only informed the registered nurse (RN). R4's Medication Administration Record dated between November 1, 2022, and November 22, 2022, indicated all medications were	02330		

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02330	Continued From page 51 administered as ordered by the provider. On November 22, 2022, at 11:30 a.m., RN-A identified the medication as amlodipine 10 milligram (mg) take one tablet by mouth once daily. RN-A stated no one had informed her that R4 was not taking all her medications as prescribed. Also, RN-A stated an investigation had been launched to know for how long R4 had not been taking all her medications. The licensee Prescriber's Order policy dated August 1, 2021, indicated the RN was responsible for implementing medication orders and delegate to appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02330		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *11/22/22*
Time: 12:45:30
Report: 1029221385

Food and Beverage Establishment Inspection Report

Location:
Berkeley Heights Homes Llc
1808 Meadowwood Court
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039029
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124339949
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

No evidence of employee illness log. Illness log emailed to Michael with instructions to record and report employee foodborne illness.

Comply By: 11/29/22

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

3-304.11A ***** Priority 1 *****

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

Dish machine broken and no sanitizer at establishment to sanitize kitchenware. Michael stated a new diswasher would be arriving on 12/12/22. I instructed Michael to obtain food contact surface sanitizer and test strips to sanitize items.

Comply By: 11/22/22

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

Opened deli meat in refrigerator without date marking. Michael stated that it had been opened within the last 24 hours. I instructed Michael to date mark items that require date marking.

Comply By: 11/22/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Splattering and food debris on cabinet and drawer surfaces. I instructed Michael to clean and maintain clean surfaces.

Comply By: 11/22/22

Food and Equipment Temperatures

Process/Item: Sliced turkey
Temperature: 38 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 37 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: Garlic in oil
Temperature: 39 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

This inspection was conducted in conjunction with an HRD survey at Berkeley Heights Homes LLC, located at 1808 Meadowwood Court, Brooklyn Park, MN 55444.

The inspection was conducted in the presence of Michael Nornie, Assisted Living Director, and other staff. All issues were discussed with Michael during and after the inspection. Employee illness reporting and exclusion procedures were also discussed in addition to general food safety practices. All issues were communicated to lead HRD surveyor and Nurse Evaluator II, Benard Nyangena, BSN, RN, following the inspection.

The kitchen has wood/pergo flooring, laminate countertops, painted wood cabinetry and drawers, and a popcorn ceiling. There was splattering and food debris on some of the drawer and cabinetry surfaces.

The dishwasher was broken, and the establishment did not have a sanitizer with the accompanying test strips to make a sanitizer solution to sanitize kitchenware and food contact surfaces. Michael stated that they had already ordered a new dishwasher and it would arrive and be installed on 12/12/22. I informed Michael that they needed to have a way to sanitize their food contact surfaces, and that if they are unable to sanitize by heat in the dishwasher, then they would need to obtain an EPA approved chemical sanitizer, that is intended sanitize food contact surfaces, and the complementary test strips to ensure the sanitizer is at the needed concentration to effectively sanitize. Michael stated that he would immediately obtain the needed sanitizer and test strips. I instructed Michael to never mix chlorine and ammonium products, or any other chemical sanitizers, unless explicitly directed to do so by the manufacturer's instructions label. I also instructed Michael to verify the new dishwasher is NSF/ANSI 184 for residential dishwashers prior to installation.

An employee illness log was emailed to Michael after the inspection.

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 1029221385 of 11/22/22.

Certified Food Protection Manager Michael Gbutu Nornie

Certification Number: FM111585 Expires: 03/22/25

Signed: _____

Michael Nornie
Assisted Living Director

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221385

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	Date	11/22/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:45:30
Legal Authority MN Rules Chapter 4626		Time Out	

Berkeley Heights Homes Llc	Address: 1808 Meadowwood Court	City/State: Brooklyn Park, MN	Zip Code: 55444	Telephone: 6124339949
License/Permit #: 0039029	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/29/22

Inspector (Signature)