DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 8, 2023

Licensee
Bentson Family Assisted Living Residence
730 Kay Avenue
Saint Paul, MN 55102

RE: Project Number(s) SL26406015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 20, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

A state correction 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).

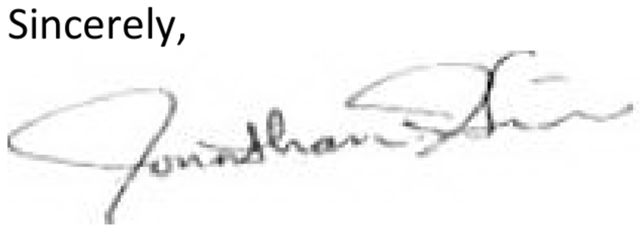
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26406	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTSON FAMILY ASST LVG RES	730 KAY AVENUE SAINT PAUL, MN 55102

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL26406015 On July 17, 2023, through July 20, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 56 active residents; 56 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 800		

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0 800	Continued From page 2 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 facility 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) 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 July 20, 2023, approximately from 11:00 a.m. to 1:15 p.m., survey staff toured the facility with the director of engineering (DE)-L, the housing director/licensed assisted living director (LALD)-A, and the campus director of engineering (CE)-M. During the tour, survey staff observed the following: -The fire-rated laundry room doors located on the 3rd and 5th floors were kept in the open position using a door pin at the top of the doors to hold open and prevent doors from self-closing for hazardous area protection during a fire. In addition, the 3rd-floor laundry room fire-rated door failed to positively latch when closed to protect and maintain the integrity of the corridor. -The spa whirlpool tub in the memory unit was out of service and in need of repair/replacement.	0 800		

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0 800	Continued From page 3 Survey staff asked about the spa tub the areas around the tub was used for storage. The DE-L and the CE-M confirmed the finding and stated that the tub needed to be repaired and had not been used for many years. The above findings were visually and/or verbally verified by the DE-L and the CE-M accompanying the tour. On July 20, 2023, at approximately 2:30 p.m., the CE-M, the LALD-A, and the DE-L acknowledged the above findings during the exit interview. No further information was provided.	0 800		
0 810 SS=C	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.	0 810		

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0 810	Continued From page 4 (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 legible floor layout plans as part of the facility's fire safety and evacuation plan . This has the potential to directly affect the safety of staff, visitors, and residents receiving care. 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 July 20, 2023, approximately from 11:00 a.m. to 1:15 p.m. survey staff toured the facility with the director of engineering (DE)-L, the housing director/licensed assisted living director (LALD)-A, and the campus director of engineering (CE)-M.	0 810		

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0 810	Continued From page 5 On July 20, 2023, approximately from 1:30 p.m. to 2:00 p.m., survey staff received the facility's fire safety and evacuation plan and related documentation for review. At approximately 2:15 p.m., document review and interview with the DE-L, the LALD-A, and the CE-M, indicated that the licensee failed to provide building floor layout plans that were legible to read as part of evacuation plan or posted layout plans with required location and number of resident sleeping rooms so they are readily available as part of the fire safety and evacuation plan. The findings were evident as the life safety plans with resident rooms (three-ring binder) that were provided for the review were in very small prints and were not legible to determine where resident rooms are located. In addition, the floor plans posted near the elevators lacked the location and number of sleeping rooms. The LALD-A, DE-L, and CE-M verbally and/or physically verified the finding during the facility tour and the interview. Additional information was received via email by the LALD-A with attached floor layout plan on Thursday 07/20/2023 at 3:35 p.m. and an additional email on Friday 7/21/2023 at 10:12 a.m. indicating that the facility have plans that are legible and printed on large paper for readable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect all 17 residents in the secured dementia care unit of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 17, 2023, at 11:58 a.m., the surveyor observed one of three medication carts stored in the hallway of the secured dementia care unit to be unlocked. The unlocked medication cart was labeled "group 8," and contained multiple medications prescribed to residents who resided in the secured dementia care unit of the facility. On July 17, 2023, at 12:10 p.m., licensed practical nurse (LPN)-C walked past the unlocked medication cart and went into a residents room to assist with care. - at 12:20 p.m., surveyor asked LPN-C about the unlocked medication cart. LPN-C indicated the medication cart was left unlocked and contained residents medications. LPN-C also stated, the caregivers were all trained to never leave the medications cart unlocked when not attended.	01880		

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01880	Continued From page 7 On July 19, 2023, at 9:04 a.m., clinical nurse supervisor (CNS)-B, and licensed assisted living director (LALD)-A stated the medication carts should always be locked when not attended. CNS-B indicated the employees know this is not okay to leave a medication cart unlocked, and CNS-B stated this will be followed up on and all of the caregivers re-educated. The licensee's Medication Storage policy dated August, 2021, indicated "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." Further included "Medications managed by [Licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).	02070		

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02070	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in the one secured dementia care unit of the facility. This had the potential to affect all 17 residents residing in the secured memory care unit. 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: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 67 residents. The licensee had a current census of 56 residents that received services, and 17 of these residents resided in the secured dementia care unit. The physical layout of the facility included a secured dementia care unit located on the second floor of the facility, and required a fob to be used for access. The assisted living (AL) areas were located on the 3rd, 4th and 5th floor of the facility. On July 17, 2023, at 10:20 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor	02070		

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02070	Continued From page 9 (CNS)-B stated the licensee's staffing schedule included two unlicensed personnel (ULPs) scheduled on the overnight shift (10:30 p.m. to 6:30 a.m.), one ULP for the secured dementia care unit, and one ULP for the AL residents. The licensee's undated master staffing plan indicated two ULP's were scheduled for each overnight shift. The staffing schedule provided to surveyors from July 17, through July 19, 2023, also indicated two ULPs worked the overnight shift from 10:30 p.m. to 6:30 a.m., one ULP for the secured dementia care unit, and one ULP for the AL residents. On July 18, 2023, at 5:45 a.m., surveyor arrived on site to the secured dementia care unit. One resident was sitting on a chair inside the entry area of the secured dementia care unit. Two ULP's from the overnight shift were in the secured dementia care unit. ULP-J was assigned to the AL floors of the facility, and ULP- I was assigned to the secured dementia care unit during the overnight shift July 17, 2023. On July 18, 2023, at 5:50 a.m. ULP-J stated, she would call "911" for a resident lift assist if there was a fall during the night shift. ULP-J also indicated there had been no recent falls that she remembered. On July 18, 2023 at 6:04 a.m., ULP-I stated, if the ULP that worked the overnight shift needed help in the AL areas of the facility, ULP-I would briefly go to help and then come right back to the secured dementia care unit where she was assigned. ULP-I indicated this is not done very often. ULP-I included the help is usually for a resident that needed two persons for a boost up in bed, or difficult toileting cares that required two	02070		

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02070	Continued From page 10 caregivers. In addition, when surveyor asked ULP-I if she needed to go assist in AL overnight on July 17, 2023, ULP-I stated "yes." R2 was admitted on February 27, 2017, and received services in the assisted living area of the facility. R2's "Resident Evaluation" dated July 11, 2023, was identified by (CNS)-B as R2's most recent RN assessment. The assessment on page 22, included a section titled "Assess for fall risk," and read, "Mechanical Hoyer lift and assist of 2 staff must be used to assist off floor for all falls." R2's Resident Service Plan with Schedule signed July 13, 2023, was identified by (CNS)-B as R2's most current authenticated service plan with services R2 was receiving. The Service Plan on page 14, included a section titled Assess for fall risk and read, "Mechanical Hoyer lift and assist of 2 staff must be used to assist off floor for all falls". On July 19, 2023, at 9:04 a.m., LALD-A and CNS-B were interviewed by surveyors on the facility plan to assist AL residents on the overnight shift. LALD-A stated if a resident falls in the facility at night, they would call the nurse on call for further instructions. No direct answer was given on the staffing plan for overnight cares if more than one person is needed to assist a resident in the AL area of the facility without the assigned ULP leaving the secured dementia care unit. Surveyor asked LALD-A and CNS-B why ULP-I may have left the secured dementia care unit on the overnight shift July 17, 2023, LALD had no response, and proceeded to avoid answering the question. In addition, surveyor discussed with LALD-A and CNS-B that it appeared the "Resident Mobility Assessments"	02070		

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02070	Continued From page 11 indicated that a two-person lift/Hoyer (mechanical lift) must be used for resident falls. LALD-A stated the ULP assigned to the secured dementia care unit at night do not leave the secured dementia care unit to help with two person lifts in the unsecured areas of the facility. LALD-A also stated the ULP on the overnight shift working in the unsecured, AL area of the facility located on 3rd, 4th, and 5th floors would call 911 for emergent/non emergent resident lift assistance. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) document dated April 27, 2023, indicated "Number of unlicensed direct care staff typically scheduled per shift: Day Shift: 6; Evening Shift: 6; and, Night shift: 2." Additionally, "Section 5: Mobility Support; Transfers with assist of one staff, sit to stand only, and Mechanical lift: assist of 2 transfer, Memory Care only." The licensee's Staffing Requirements -licensed nurse and ULP policy dated August 2021, showed "All staff of [Licensee] persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs and promote and be trained to support the assisted living bill of rights." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26406	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTSON FAMILY ASST LVG RES	730 KAY AVENUE SAINT PAUL, MN 55102

(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 12 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 provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R2, R4) who utilized hospital side rails. 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: SIDE RAILS: R2 On July 17, 2023, at approximately 11:00 a.m., during care observation, the surveyor observed a hospital style bed with raised bilateral (both sides of the bed) upper ½ side rails on R2's occupied hospital bed. R2 was admitted to the licensee on February 27, 2017. R2's signed Service Plan with Schedule dated July 13, 2023, indicated R2 received services including a hospital bed with side rails in use. R2's registered nurse (RN) assessment dated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26406	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTSON FAMILY ASST LVG RES	730 KAY AVENUE SAINT PAUL, MN 55102

(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 13 July 11, 2023, indicated R2's bilateral side rail zones one through four were measured and are within the parameters of FDA guidelines (4" ¾ and 2" 3/8). The assessment lacked documentation of actual measurements for R2's side rails on zones one through four. R4 On July 18, 2023, at 6:30 a.m. during care observations in the secured dementia care unit surveyor observed two hospital beds located in R4's apartment. Both beds were hospital style beds with upper 1/2 side rails and were observed to be in the upright position. R4 was observed prior to cares, lying supine in the hospital bed closest to R4's door entry, and the bilateral 1/2 side rails were in the upright position. The second hospital bed in R4's apartment was empty, and located near the back of the apartment. R4 was admitted to the licensee's secured dementia care unit on April 26, 2023. R4 had diagnoses to include Alzheimer's disease, and hemiplegia affecting the left non-dominant side. R4's signed service plan dated April 26, 2023, indicated R4 received assistance with meals, laundry, housekeeping, bathing, grooming, toileting, transfers, and medication administration. R4's Risk Agreement-Bed Rails form dated July 5, 2023, signed by RN, lacked a signature from the resident or residents representative. The risk agreement form included "Observation of bed rails for hospital beds," contained check marks in the side rail zones within the parameters of FDA guidelines (4" ¾ and 2" 3/8), without actual side rail zone measurements. R4's risk agreement lacked evidence of actual measurements for the side rails.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26406	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTSON FAMILY ASST LVG RES	730 KAY AVENUE SAINT PAUL, MN 55102

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02310	Continued From page 14 R4's nursing assessment dated July 6, 2023, included R4's hospital bed with 1/2 side rails that R4 currently slept in. The RN assessment included "reassessing clients outside hospital type bed and use of 2 upper 1/2 rails. The rails are more wobbly than they should be. Concern is we have no one to perform maintenance on bed. The bed is not sold in the USA. It was bought on craigs list prior to her moving in .. [sic] This nurse was told by a vendor in the USA that there is only one technician that works on this bed and he lives in new jersey. Unclear reading manufacturers iinfo [sic] fit meets FDA quidelines [sic]s. The bed was made in Germany. It may be older then 20 years. Family have okayed us trying to get hospital bed from local vendor covered by her Medicare." Further, R4's nursing assessment lacked evidence of actual measurements for the side rails. On July 18, 2023, at 6:30 a.m., licensed practical nurse (LPN)-C stated the facility is in the processed to change out R4's hospital bed, from the one R4 slept in last night, nearest to door entry, to the one located in the back of R4's apartment. LPN-C was unsure of when the hospital bed transition would take place. LPN-C included the facility had been working with R4's family on having her current hospital bed changed out due to concerns with the side rails. On July 18, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor brought surveyor a yellow post it note with measurements for R4's hospital side rails. Surveyor asked when these measurements were taken, and CNS-B indicated they were measured this morning.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26406	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTSON FAMILY ASST LVG RES	730 KAY AVENUE SAINT PAUL, MN 55102

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02310	Continued From page 15 On July 19, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated, there were no actual measurements for R4's side rails that could be found. In addition, CNS-B showed surveyor a wooden block with the FDA measurements (4" 3/4 and 2" 3/8), and stated the wooden block was used by the facility to check the zones of the side rails to meet compliance. The licensee's Grab bar/bed assist device policy dated July 12, 2022, included: "4. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines manufacturer's instructions. b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions." The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/18/23*
Time: 13:58:37
Report: 1023231136

Food and Beverage Establishment Inspection Report

Location:
Bentson Family Asst Lvg Res
730 Kay Avenue
St Paul, MN55102
Ramsey County, 62

Establishment Info:
ID #: 0038526
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513282000
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.

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

MEASURED SANTIZER IN BISTRO 3 COMP SINK TOO LOW. ADJUST CHEMICALS TO CORRECT LEVELS.

Comply By: 07/18/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

MULTIPLE PIECES OF EQUIPMENT BROKEN. REPAIR/REPLACE EQUIPMENT SUCH AS REACH IN COOLER, DISH MACHINE, AND VENTILATION HOODS.

Comply By: 07/18/23

Surface and Equipment Sanitizers

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

Hot Water: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 100PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 39 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SAUCE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER BISTRO
Violation Issued: No

Process/Item: Hot Hold/QUICHE
Temperature: 148 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS ALL COMMERCIAL GRADE ANSI EQUIPMENT. THERE IS A MAIN KITCHEN, BISTRO AREA, AND A MEMORY CARE SERVICE KITCHEN. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

Type: Full
Date: *07/18/23*
Time: 13:58:37
Report: 1023231136
Bentson Family Asst Lvg Res

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023231136 of 07/18/23.

Certified Food Protection Manager: DANARA JEFFERSON

Certification Number: 12954 Expires: 09/13/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
DANARA JEFFERSON
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us