Electronically Delivered

March 26, 2025

Licensee
Beatitudes Homes LLC
1609 84th Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37087016

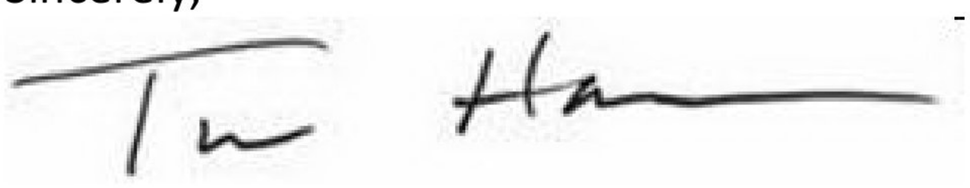
Dear Licensee:

On February 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 21, 2024, 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,



Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

December 31, 2024

Licensee
Beatitudes Homes LLC
1609 84th Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37087016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 may be 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

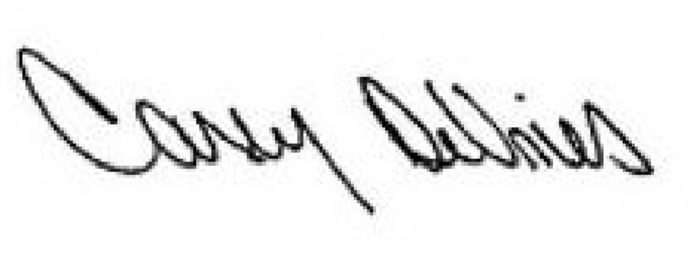
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEATITUDES HOMES LLC	1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428

(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 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: SL37087015-0 On November 18, 2024, through November 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five resident(s); five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 18, 2024, at 9:36 a.m., during a facility tour, the surveyor observed a split-level	0 460		

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0 460	Continued From page 2 home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas. On November 19, 2024, at 7:34 a.m., house manager (HM)-B stated residents did not have the means to request assistance with a call light, call pendant, or bells. HM-B stated residents were all independent and residents could call out for assistance if needed. On November 20, 2024, at 8:52 a.m., licensed assisted living director (LALD)-D stated they were aware the licensee needed to provide a means for residents to request assistance. LALD-D stated they had ordered call pendants to be delivered to the assisted living facility (ALF) but may have been delivered to the sister facility in error. The licensee's 2.01 24-Hour Emergency Response policy dated October 11, 2021, indicated the licensee would provide a means for residents to request help from staff in an emergency. The policy also indicated activating the emergency response button would notify a designated staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (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	0 470		

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0 470	Continued From page 3 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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470		

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0 470	Continued From page 4 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 18, 2024, at 10:11 a.m., owner/agent (O/A)-A stated one unlicensed personnel (ULP) worked per shift and the shift schedule was 7:00 a.m., until 3:00 p.m., 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00 a.m. O/A-A stated the clinical nurse supervisor (CNS) was on call 24 hours per day, seven days a week and did not have set working hours at the assisted living facility. On November 19, 2024, at 12:48 p.m., O/A-A provided a document titled [licensee] Homes Staffing Plan dated October 28, 2024, and stated it was the facility's staffing plan. The staffing plan lacked staffing availability based on resident care requirements. On November 20, 2024, at 9:51 a.m., clinical nurse supervisor (CNS)-C stated they were unaware of the required content for the staffing plan and believed the current staffing plan met the statutory requirements. The licensee's 5.06 Staffing and Scheduling policy dated October 11, 2024, indicated the following, "The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location."	0 470		

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0 470	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, and medical and nursing standards for infection control for one of one staff (home manager (HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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	0 510		

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0 510	Continued From page 6 of the residents). The findings include: On November 19, 2024, at 8:20 a.m., the surveyor observed HM-B perform hand hygiene and place a pair of gloves on. HM-B removed a bubble pack of medications from the file cabinet for R5 and walked to the kitchen counter. HM-B used a laptop computer to verify the medications against R5's electronic medication record (EMAR) for R5 and placed the medications into a medication cup. With R5 sat at the dining table, HM-B handed the medication cup to R5, R5 swallowed the medications, and handed the medication cup back to HM-B. HM-B placed the medication cup into a trash can. On November 19, 2024, at 8:42 a.m., with the same pair of gloves on, the surveyor observed HM-B use an infrared thermometer (a device to record a person's temperature without directly touching the person) on R2. HM-B documented the temperature reading in RTasks (an electronic medical record). HM-B removed a small basket containing medication cards for R2 from the black filing cabinet. HM-B verified the medications against R2's EMAR and placed the medications into a medication cup. HM-B handed the medication cup to R2, and they swallowed the medications. HM-B returned R2's medications to the black file cabinet. On November 19, 2024, at 8:45 a.m., with the same pair of gloves on, the surveyor observed HM-B remove medication cards for R3. HM-B verified the medications for R3's on the EMAR, placed the medications into a medication cup and handed the medication cup to R3. HM-B removed the right glove and held it in their left hand. HM-B	0 510		

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0 510	Continued From page 7 looked at the EMAR for R3 and clicked administered. HM-B then put the same glove back onto their right hand. HM-B used the infrared thermometer on R3 and recorded the reading in RTask. On November 19, 2024, at 8:55 a.m., the surveyor observed HM-B remove both gloves and perform hand hygiene. On November 19, 2024, at 8:47 a.m., HM-B stated they were trained by the nurse to change gloves between each resident. HM-B stated they did not touch the medications, so they did not have to change gloves between each resident. On November 19, 2024, at 9:36 a.m., and 1:57 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for the infection control practices for the assisted living facility. CNS-C stated staff were trained to change gloves and wash hands between each resident. CNS-C stated staff did not always follow the training and was an oversight for not changing gloves between each resident. The licensee's 8.01 Infection Control Policy dated October 11, 2021, indicated the licensee's infection control program would be consistent with current guidelines from the Center for Disease Control (CDC). The Center for Disease Control (CDC) Hand Hygiene for Healthcare workers dated February 27, 2024, recommends changing gloves and performing hand hygiene between each patient. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 8 days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 640		

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0 640	Continued From page 9 On November 18, 2024, at 9:36 a.m., during a facility tour, the surveyor observed a split-level home, in the upper level in the common area by the telephone, there was a landline telephone. There was no 911 emergency number close to the telephone. On November 19, 2024, at 1:32 p.m., the surveyor observed R3 use the landline telephone. On November 20, 2024, at 9:02 a.m., licensed assisted living director (LALD)-D stated they were aware the 911 emergency number was required to be posted near the landline telephone. LALD-D stated it was an oversight for not posting the required emergency number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 10 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated August 16, 2024, lacked evidence of the following required content: -process for EP collaboration with local, tribal, regional, State and Federal officials/organizations; - arrangements with other facilities;	0 680		

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	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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0 680	Continued From page 11 - roles under a waiver declared by secretary; - names and contact information for staff, entities providing services under agreement, residents physicians, other facilities, and volunteers; - emergency official contact information for State licensing and certification agency, and; - emergency prep testing requirements, including staff drills using the emergency preparedness plan. On November 20, 2024, at 9:14 a.m., licensed assisted living director (LALD)-D stated they were responsible for the EP plan for the assisted living facility (ALF). LALD-D stated they were aware of the required content for the EP plan, and it was an oversight for the EP plan had not contained all the required information. The licensee's 9.01 Emergency Preparedness plan dated October 11, 2021, indicated the licensee would have an emergency preparedness plan that aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	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	0 780		

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0 780	Continued From page 12 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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511, and the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. 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	0 780		

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0 780	Continued From page 13 portion or all of the residents). The findings include: On November 19, 2024, from 10:20 a.m. to 12:15 p.m., the surveyor toured the facility with owner/agent (O/A)-A. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: CIGARETTE DISPOSAL Resident room 4 in the lower level was being used as a smoking area by resident (R1). There was used cigarette smoking materials, ash, and burn marks on the top of the small writing desk adjacent to the bed. The blankets on the bed had burn marks in two locations. The carpet and rug below the small writing desk and bed had ash spilled and ground into the material. A black, plastic cup was on the small writing desk that was used by R1 as an ashtray. Used cigarette smoking materials are required to be discarded in appropriate containers in the designated, exterior smoking areas. There were appropriate containers provided for discarding the used cigarette butts outside. O/A-A stated they suspected R1 was smoking in their room, but never caught them. SMOKE ALARMS Upon testing, it was found that the smoke alarms in the facility were not interconnected. O/A-A stated the smoke alarms were recently tested and interconnected and didn't know why they were not working at the time of the survey. These deficient conditions were visually verified by O/A-A accompanying on the tour. On November 19, 2024, at 1:00 p.m., O/A-A	0 780		

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0 780	Continued From page 14 stated they would get the smoke alarms interconnected. TIME PERIOD FOR CORRECTION: Two (2) 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 and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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:	0 790		

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0 790	Continued From page 15 On November 19, 2024, from 10:20 a.m. to 12:15 p.m., the surveyor toured the facility with owner/agent (O/A)-A. The portable fire extinguishers throughout the facility lacked records to show the required monthly visual inspections were completed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On November 19, 2024, at 1:00 p.m., the surveyor explained to O/A-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. O/A-A stated they did not know monthly inspections were required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 16 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, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, from 10:20 a.m. to 12:15 p.m., the surveyor toured the facility with owner/agent (O/A)-A. The following was observed: In resident room 4 there was an excessive amount of belongings causing there to only be a path 14 inches wide at the foot of the bed, and a path 10 inches wide on the left-hand side of the bed. The surveyor was not able to adequately survey the resident room due to the lack of access to the room without the surveyor walking	0 800		

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0 800	Continued From page 17 on resident belongings. The door to the resident room was not able to be opened completely due to the personal belongings stored behind it. Access to the emergency escape and rescue opening (window) was obstructed by a 5 gallon water jug partially filled with coins, a wicker mirror, shopping bags, a collections of movie cases, candles, artificial flowers, and other miscellaneous personal belongings. All resident rooms shall have a storage configuration that allows safe access to the room and means of egress for the residents, staff, and emergency responders. There was a hole in the stairwell wall leading down to the lower level that was approximately the size of an adult fist in diameter. The ceiling texture in the lower level bathroom was falling off adjacent to the exhaust fan. On November 19, 2024, O/A-A stated they were working with resident (R1) to clean out the room. TIME PERIOD FOR CORRECTION: Seven (7) days	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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 18 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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	0 810		

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0 810	Continued From page 19 or has potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, owner/agent (O/A)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's policy, titled "Emergency Preparedness Plan", undated, failed to include the following: The Emergency Preparedness Plan did not include a section specific to fire safety and evacuation. On November 19, 2024, at 1:30 p.m., O/A-A stated they did not know if they had a policy specific to fire safety and evacuation and could not provide one. TRAINING The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained in August 2024 at a staff meeting. No other training documentation was provided. On November 19, 2024, at 1:30 p.m., O/A-A stated they didn't understand the training requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at	0 810		

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0 810	Continued From page 20 least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Report", undated, indicated evacuation drills were conducted on December 5, 2021, November 20, 2023, February 9, 2024, April 18, 2024, and September 23, 2024. No other documentation was provided. On November 19, 2024, at 1:30 p.m., O/A-A stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 830		

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0 830	Continued From page 21 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 was admitted to the facility on October 26, 2020, and began receiving direct care services. R1's diagnoses included diabetes type II, dyslipidemia (disorder that occurs when there were abnormal levels of fats or fat proteins in the blood), headaches, hypertension (high blood pressure), retinopathy (disease that damages light sensitive tissues at the back of the eye), tobacco abuse, polyneuropathy (disease that affects multiple nerves), depressive disorder, and chronic low back pain. R1's Service Plan (Waiver) - Addendum to Contract dated November 4, 2024, indicated R1 received assistance with activity assistance, appointment reminders, bedmaking, behavior management, clean bathroom, deep room clean, dressing, housekeeping, laundry, linen change, meal assistance and reminder, medication assistance and administration, nail care, vital signs, remove garbage, safety check, shopping assistance, skin treatment, and glucose monitoring. On November 18, 2024, at 9:33 a.m., the surveyor entered the assisted living facility (ALF). There was a strong smell of cigarette smoke. On November 18, 2024, at 9:40 a.m., during a facility tour in the lower level of the split-level home, the surveyor observed R1's bedroom. In	0 830		

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0 830	Continued From page 22 the room there was a bed, next to the bed was a small table, a wooden chair, and a dresser. The room was cluttered with personal effects. On the small table was a packet of cigarettes, a lighter, and a black pot that contained 13 cigarette ends, one of which was discolored brown with burn marks. There was cigarette ash surrounding the metal pot. On the floor by the small table was an irregular shaped formation of cigarette ash on the black and white striped rug, approximately the size of an adult hand. On R1's bedding were two small circular holes with a black burn edge around the hole. On November 18, 2024, at 9:45 a.m., R1 stated they smoked in their room, and the last time was the previous night. R1 stated the owner of the facility was aware they smoked inside their room and had several discussions about not smoking in the facility. On November 18, 2024, at 9:50 a.m., owner/agent (O/A)-A stated they were aware R1 smoked in their room. O/A-A had notified the case manager and Office of Ombudsman for Long-Term Care (an independent State agency that serves people needing or receiving long-term care through complaint, investigation, advocacy, and education) related to the smoking. O/A-A stated they attempted to evict R1 related to the non-compliance of smoking in the facility. O/A-A stated that the situation was appealed by R1 and R1 was not evicted. O/A-A stated there was documentation in R1's medical chart related to the situation. On November 18, 2024, at 11:23 a.m., O/A-A stated they were unable to find the documentation related to the situation regarding R1 smoking in the facility, the meeting with the case manager, or	0 830		

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0 830	Continued From page 23 the notification made to the Ombudsman. O/A-A stated the registered nurse was responsible for documenting the situation related to R1 smoking in the facility. On November 18, 2024, at 11:43 a.m., clinical nurse supervisor (CNS)-C stated they were unaware R1 smoked in the assisted living facility. CNS-C stated there was no documentation in R1's medical chart related to R1 smoking in the facility, and it was an oversight for staff not documenting the situation. On November 18, 2024, at 11:45 a.m., R1 stated the reason for smoking in their room was they were not able to get up at night. During the survey, the surveyor observed R1 walking up and down the stairs independently and with a steady gait (manner of walking or moving). The surveyor observed R1 enter a car and leave the ALF. On November 20, 2024, at 9:07 a.m., and 9:41 a.m., licensed assisted living director (LALD)-D stated residents were required to smoke in designated areas which were outside, and smoking was not allowed inside the facility. LALD-D stated they were aware R1 smoked inside the facility but had not observed the cigarette ends or ash in R1's room. LALD-D stated staff were required to document if they observed R1 smoking in the facility and staff should have documented any conversations with the case manager or Ombudsman. LALD-D stated that it was an oversight for not having that documentation completed by staff. On November 26, 2024, at 9:45 a.m., and 10:25 a.m., via telephone and email, case manager	0 830		

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0 830	Continued From page 24 (CM)-F stated they were a new case manager for R1 and were not aware of R1 smoking in the facility. CM-F's email indicated they reviewed all the case notes from 2021 through November 2024 related to R1. There was no documentation related to R1 smoking in the facility. CM-F stated the only recorded note related to smoking was R1 was attempting to cease smoking. The licensee's 4.59 Smoking/Tobacco Use policy dated October 10, 2021, indicated smoking, tobacco, and e-cigarettes were prohibited inside the ALF. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include: carrying or using an activated electronic delivery device. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled 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.	0 830		

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	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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0 830	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370		

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01370	Continued From page 26 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (house manager (HM)-B, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HM-B HM-B was hired on May 8, 2020, to provide direct care services. On November 19, 2024, at 8:20 a.m., the surveyor observed HM-B administer medications to R5. HM-B's employee record lacked evidence of the	01370		

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01370	Continued From page 27 following: Training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider, and; - basic nutrition, meal preparation, food safety, and assistance with eating. ULP-E ULP-E was hired on December 24, 2021, to provide direct care services. ULP-E's employee record lack evidence of the following: Training: - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional, and; - awareness of commonly used health technology equipment and assistive devices. Demonstration of Competency: - appropriate and safe techniques in personal hygiene and grooming; - hair care and bathing including; - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting, and; - standby assistance techniques and how to perform them. On November 21, 2024, at 8:02 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for training staff that provided direct care services to residents. CNS-C stated they reviewed employee files to ensure they had medication administration and treatment competencies completed. CNS-C stated they did	01370		

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01370	Continued From page 28 not check on the remaining required training, as they believed staff had already completed it. On November 21, 2024, at 8:34 a.m., owner/agent (O/A)-A stated they were responsible for assigning the training and ensuring the trainings were completed. O/A-A stated it was not completed due to, "work overload." The licensee's 5.02 Competency Training Evaluations policy dated October 11, 2021, indicated training and competency for staff members would include: reports of changes in the resident's condition to the supervisor designated by the facility, appropriate and safe techniques in personal hygiene and groom (which included hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting), standby assistance techniques and how to perform them, basic nutrition, meal preparation, food safety, and assistance with eating, preparation of modified diets as ordered by a licensed health professional, and awareness of commonly used health technology equipment and devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

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01380	Continued From page 29 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (house manager (HM)-B, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HM-B HM-B was hired on May 8, 2020, to provide direct care services.	01380		

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01380	Continued From page 30 On November 19, 2024, at 8:20 a.m., the surveyor observed HM-B administer medications to R5. HM-B's employee record lacked evidence of the following: Training: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-E ULP-E was hired on December 24, 2021, to provide direct care services. ULP-E's employee record lack evidence of the following: Training: - recognizing physical, emotional, cognitive, and developmental needs of the resident. Demonstration of Competency: - safe transfer techniques and ambulation, and; - range of motioning and positioning. On November 21, 2024, at 8:02 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for training staff that provided direct care services to residents. CNS-C stated they reviewed employee files to ensure they had medication administration and treatment competencies completed. CNS-C stated they did not check on the remaining required training, as they believed staff had already completed it.	01380		

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01380	Continued From page 31 On November 21, 2024, at 8:34 a.m., owner/agent (O/A)-A stated they were responsible for assigning the training and ensuring the trainings were completed. O/A-A stated it was not completed due to, "work overload." The licensee's 5.02 Competency Training Evaluations policy dated October 11, 2021, indicated training and competency for staff members would include: "a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 32 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 33 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (clinical nurse supervisor (CNS)-C). 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: CNS-C was hired on February 1, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the	01470		

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01470	Continued From page 34 following: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On November 21, 2024, at 11:02 a.m., CNS-C stated the orientation training consisted of the previous CNS reviewing the facility staff plan, resident treatments, and resident cares. CNS-C stated no documentation was completed to prove the orientation to the assisted living facility (ALF) was conducted. On November 21, 2024, at 7:42 a.m., licensed assisted living director (LALD)-D stated the owner/agent was responsible for the orientation training for staff. LALD-D stated CNS-C was not required to have completed all the required training as they were already a registered nurse (RN). LALD-D stated they would have to review with the owner/agent to determine which trainings needed to be completed. On November 22, 2024, at 8:34 a.m., owner/agent (O/A)-A stated they assigned all the required classes to all staff members. O/A-A stated they were not aware CNS-C had not completed the required orientation training until	01470		

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01470	Continued From page 35 the surveyor requested to review CNS-C's employee file. O/A-A stated it was not completed due to, "work overload." The licensee's 5.01 Orientation and Training policy dated October 11, 2021, indicated orientation training for staff would include the following: "-An overview of the appropriate Assisted Living statutes and rules -An introduction and review of the facility's policies and procedures re ted to the provision of -assisted living services by the individual staff person -Handling of emergencies and use of emergency services -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complaints, and whe11 to report complaints, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long- erm Care, Office of Ombudsman for Mental Health and Developmental Disability s, Managed Care Ombudsman at the Department of Human Services, county-ma aged care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure	01470		

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01470	Continued From page 36 -The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist di closure of services -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01530		

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01530	Continued From page 37 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of three employees (clinical nurse supervisor)-C). 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: CNS-C was hired on February 1, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked the following required content: - dementia training required for all direct care staff and supervisors, and; - initial 8 hours of dementia care training within	01530		

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01530	Continued From page 38 120 hours. On November 20, 2024, at 10:11 a.m., CNS-C stated they worked full time for the assisted living facility (ALF), they did not have set hours, were on call for the ALF, and would present to the ALF when they were needed to address situations with residents. On November 20, 2024, at 11:16 a.m., owner/agent (O/A)-A stated CNS-C did not use a time clock to record their hours worked at the ALF. O/A-A stated they were unsure of the number of hours CNS-C worked per week. On November 21, 2024, at 7:49 a.m., licensed assisted living director (LALD)-D stated O/A-A was responsible for ensuring staff had completed the required dementia care training. LALD-D stated they did not know why CNS-C had not completed the required dementia training. On November 21, 2024, at 8:43 a.m., O/A-A stated they were aware of the required number of hours for dementia care training. O/A-A stated they were unsure why CNS-C had not completed the required dementia care training. The licensee's 5.03 Dementia Training policy dated October 11, 2021, indicated supervisors of direct care staff will complete eight hours of initial training with 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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01760	Continued From page 39	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescribers orders were accurately transcribed for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted to the facility on October 26, 2020, and began receiving direct care services.	01760		

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01760	Continued From page 40 R1's diagnoses included diabetes type II, dyslipidemia (disorder that occurs when there were abnormal levels of fats or fat proteins in the blood), headaches, hypertension (high blood pressure), retinopathy (disease that damages light sensitive tissues at the back of the eye), tobacco abuse, polyneuropathy (disease that affects multiple nerves), depressive disorder, and chronic low back pain. R1's Service Plan (Waiver) - Addendum to Contract dated November 4, 2024, indicated R1 received assistance with activity assistance, appointment reminders, bedmaking, behavior management, clean bathroom, deep room clean, dressing, housekeeping, laundry, linen change, meal assistance and reminder, medication assistance and administration, nail care, vital signs, remove garbage, safety check, shopping assistance, skin treatment, and glucose monitoring. R1's signed prescription orders dated July 14, 2024, indicated R1 was prescribed the following medications: acetaminophen 325 milligrams (mg), albuterol sulfate 90 mcg, amlodipine 2.5 mg 1 tablet daily, ascorbic acid 250 mg, aspirin 81mg 2 tablets once daily, vitamin D3 25 micrograms (mcg) once daily, docusate sodium 1 capsule twice daily as needed, duloxetine 60 mg 1 capsule once daily, escitalopram 10 milligrams (mg) 1 tablet daily, ferrous sulfate 325 mg 1 tablet once daily, Advair HFA (hydrofluoroalkane), furosemide 20 mg 1 tablet once daily, Lantus Solostar 100 units (u) inject 30 units subcutaneously once daily, ketoconazole cream 2% apply to feet twice daily as needed, lidocaine ointment 5 percent (%), lisinopril 40 mg 1 tablet once daily, metformin 400 mg extended release 4 tablets once daily, metoprolol 150 mg once daily,	01760		

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01760	Continued From page 41 naloxone 4mg/0.1mg, omeprazole 20 mg 1 capsule once daily, sildenafil 100 mg 1 tablet as needed, and simvastatin 20 mg 1 tablet once daily, petroleum gel apply to dry skin on both feet, and tamsulosin 0.4 capsule once daily. R1's medication administration record (MAR) dated November 1, 2024, through November 31, 2024, indicated R1 received the following medications: escitalopram 10 milligrams (mg) 1 tablet daily, Advair HFA (hydrofluoroalkane), amlodipine 2.5 mg 1 tablet daily, aspirin 81mg 2 tablets once daily, duloxetine 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, furosemide 20 mg 1 tablet once daily, Lantus Solostar 100 units (u) inject 30 units subcutaneously once daily, lisinopril 40 mg 1 tablet once daily, metformin 400 mg extended release 4 tablets once daily, nicotine transdermal (through the skin) 21mg/24 hours apply one patch topically (directly on skin), omeprazole 20 mg 1 capsule once daily, tamsulosin 0.4 capsule once daily, vitamin D3 25 micrograms (mcg) once daily, metoprolol 150 mg once daily, simvastatin 20 mg 1 tablet once daily, lidocaine ointment 5 percent (%), oxycodone/acetaminophen 5mg/325 mg 1 tablet three times daily as needed, acetaminophen 325 2 tablets every six hours as needed - not to exceed 4000mg every 24 hours, albuterol inhaler inhale 2 puffs by mouth every 6 hours as needed, cetirizine 10 mg 1 tablet once daily as needed, deep sea saline nasal spray 1 spray into the nose three times daily as needed, docusate sodium 1 capsule twice daily as needed, hydrocortisone 2.5% cream apply to soles of feet as needed, ketoconazole cream 2% apply to feet twice daily as needed, nicotine polarcrilex chewing gum chew 1 piece 5-6 times as needed, petroleum gel apply to dry skin on both feet, sildenafil 100 mg 1 tablet as needed,	01760		

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01760	Continued From page 42 and Ventolin 90 mcg inhale 2 puffs every six hours as needed. R1's prescriber orders indicated R1 was prescribed ascorbic acid 250 mg and naloxone 4/0.1 mg but they were not listed on the MAR. On November 20, 2024, at 9:23 a.m., licensed assisted living director (LALD)-D stated the registered nurse was responsible for ensuring the signed medical prescriber orders matched residents MARs. LALD-D stated they were unsure why there was medications missing from the MAR. On November 20, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated they were aware licensee was required to have signed prescription orders in the resident chart. CNS-C was stated they did not know why the signed medical prescriber orders did not match the MAR. The licensee's 7.17 Medication and Treatment Orders - Receiving policy dated October 11, 2021, indicated the nurse will obtain all medication and treatment orders either in writing, verbally, or electronically by an authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	01820		

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01820	Continued From page 43 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to maintain current signed prescription orders for all medications the licensee was managing for two of three residents (R2, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the facility on October 26, 2020, and began receiving direct care services. R2's diagnoses included cognitive disorder (a disorder that impacts abilities like learning, memory, perception, and problem solving), chronic venous insufficiency (a condition when the veins have difficulty returning blood back to the heart), schizo-affective disorder (a mental health disorder that includes depression and bipolar disorder (extreme mood swings, along with changes in energy, sleeping, thinking, and behavior) and when a person experiences sees, hears, tastes, or feels things that are not actually there), and traumatic brain injury. R2's Service Plan (Waiver) - Addendum to Contract dated effective November 4, 2024,	01820		

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01820	Continued From page 44 included activity assistance, appointment reminder, bathing reminder, bedmaking, behavior management, clean bathroom, deep room clean, dressing, exercise, grooming, housekeeping, laundry, linen exchange, meal reminder, medication assistance and administration, nail care, vital signs, remove garbage, safety check, and shopping assistance. R2's medication administration record (MAR) dated November 1, 2024, through November 31, 2024, indicated R2 received the following medications: sertraline 50 milligram (mg) 1 table once daily, Abilify Maintena 300 mg injection into subcutaneous (under the first layer of skin) 1 time monthly, acetaminophen 325 mg 2 tablets every 6 hours as needed, albuterol 0.083 percent (%) nebulize (turns liquid into a breathable mist) 1 via every 6 hours as needed, bacitracin zinc neomycin sulfate polymyxin B apply to leg rash as needed, ondansetron 4 mg 1 tablet every 6 hours as needed, and Ventolin 90 micrograms (mcg) 1-2 puffs by mouth every 4 hours as needed. The following medications were listed on the MAR but were not included in the medication prescription orders: acetaminophen 325 mg 2 tablets every 6 hours as needed, albuterol 0.083 percent (%) nebulize (turns liquid into a breathable mist) 1 via every 6 hours as needed, bacitracin zinc neomycin sulfate polymyxin B apply to leg rash as needed, ondansetron 4 mg 1 tablet every 6 hours as needed, and Ventolin 90 micrograms (mcg) 1-2 puffs by mouth every 4 hours as needed. R3 R3 was admitted to the facility on January 30, 2022, and began receiving direct care services.	01820		

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01820	Continued From page 45 R3's diagnoses included attention-deficit/hyperactivity disorder (a neurodevelopmental disorder that affects a person's behavior, memory, motor skills, or ability to learn), mood disorder (mental health condition that causes long-term changes in a person's emotional state), autism spectrum disorder (neurological and developmental disorder that affects how people interact with others, communicates, learns and behaves), and generalized anxiety disorder, R3's MAR indicated R3 received the following medications: buspirone 7.5 mg one tablet once daily, guanfacine 1 mg, one tablet twice daily, methylphenid 36 mg total extended release one tablet once daily, artificial tears 1 drop in each eye, sertraline 100 mg 2 tablets once daily, trazadone 100 mg 1 tablet at bedtime, cold and flu take 30 millimeters (ml) every 6 hours, and Eucerin cream. R3's medical chart lacked prescriber orders. On November 20, 2024, at 9:23 a.m., licensed assisted living director (LALD)-D stated the registered nurse was responsible for ensuring the signed medical prescriber orders matched residents MARs. LALD-D stated they were aware the licensee was required to have signed prescription orders on file for each resident. LALD-D stated they were unsure why there was medications missing from the MAR and why there were missing orders. On November 20, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated signed medical prescriber orders should match the resident MAR, and was aware licensee was required to	01820		

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01820	Continued From page 46 have signed prescription orders in the resident chart. CNS-C stated they did not know why the signed medical prescriber orders did not match the MAR and was not aware a copy of the prescription orders was not on file. The licensee's 7.17 Medication and Treatment Orders - Receiving policy dated October 11, 2021, indicated the nurse will obtain all medication and treatment orders either in writing, verbally, or electronically by an authorized prescriber. The licensee's 7.20 Medication and Treatment Orders policy dated October 11, 2021, indicated the licensee would ensure the medical prescriber would renew medications and treatments every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R2).	01830		

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01830	Continued From page 47 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: R2 was admitted to the facility on October 26, 2020, and began receiving direct care services. R2's diagnoses included cognitive disorder (a disorder that impacts abilities like learning, memory, perception, and problem solving), chronic venous insufficiency (a condition when the veins have difficulty returning blood back to the heart), schizo-affective disorder (a mental health disorder that includes depression and bipolar disorder (extreme mood swings, along with changes in energy, sleeping, thinking, and behavior) and when a person experiences sees, hears, tastes, or feels things that are not actually there), and traumatic brain injury. R2's Service Plan (Waiver) - Addendum to Contract dated effective November 4, 2024, included activity assistance, appointment reminder, bathing reminder, bedmaking, behavior management, clean bathroom, deep room clean, dressing, exercise, grooming, housekeeping, laundry, linen exchange, meal reminder, medication assistance and administration, nail care, vital signs, remove garbage, safety check, and shopping assistance. R2's medication administration record (MAR)	01830		

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01830	Continued From page 48 dated November 1, 2024, through November 31, 2024, indicated R2 received the following medications: sertraline 50 milligram (mg) 1 table once daily, Abilify Maintena 300 mg injection into subcutaneous (under the first layer of skin) 1 time monthly, acetaminophen 325 mg 2 tablets every 6 hours as needed, albuterol 0.083 percent (%) nebulize (turns liquid into a breathable mist) 1 via every 6 hours as needed, bacitracin zinc neomycin sulfate polymyxin B apply to leg rash as needed, ondansetron 4 mg 1 tablet every 6 hours as needed, and Ventolin 90 micrograms (mcg) 1-2 puffs by mouth every 4 hours as needed. R2's medical chart included signed medication prescription orders dated October 27, 2021, through October 27, 2022. R2's medical chart lacked current signed orders from a medical provider dated within a 12-month period. On November 20, 2024, at 9:23 a.m., licensed assisted living director (LALD)-D stated the registered nurse (RN) was responsible for ensuring there were current orders in R2's chart. LALD-D stated they did not have a reason for not having current orders. On November 20, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated prescription orders should be renewed within one year. CNS-C stated they believed the orders were current and up to date for R2. The licensee's 7.20 Medication and Treatment Orders policy dated October 11, 2021, indicated the licensee required the registered nurse (RN) have the prescriber renew the medication orders at least every 12 months. No further information was provided.	01830		

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01830	Continued From page 49 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted to the facility on October 26, 2020, and began receiving direct care services. R1's diagnoses included diabetes type II, dyslipidemia (disorder that occurs when there were abnormal levels of fats or fat proteins in the	01880		

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01880	Continued From page 50 blood), headaches, hypertension (high blood pressure), retinopathy (disease that damages light sensitive tissues at the back of the eye), tobacco abuse, polyneuropathy (disease that affects multiple nerves), depressive disorder, and chronic low back pain. R1's Service Plan (Waiver) - Addendum to Contract dated November 4, 2024, indicated R1 received assistance with activity assistance, appointment reminders, bedmaking, behavior management, clean bathroom, deep room clean, dressing, housekeeping, laundry, linen change, meal assistance and reminder, medication assistance and administration, nail care, vital signs, remove garbage, safety check, shopping assistance, skin treatment, and glucose monitoring. R1's medication administration record (MAR) dated November 1, 2024, through November 31, 2024, indicated R1 received the following medications: escitalopram 10 milligrams (mg) 1 tablet daily, Advair HFA (hydrofluoroalkane), amlodipine 2.5 mg 1 tablet daily, aspirin 81mg 2 tablets once daily, duloxetine 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, furosemide 20 mg 1 tablet once daily, Lantus Solostar 100 units (u) inject 30 units subcutaneously once daily, lisinopril 40 mg 1 tablet once daily, metformin 400 mg extended release 4 tablets once daily, nicotine transdermal (through the skin) 21mg/24 hours apply one patch topically (directly on skin), omeprazole 20 mg 1 capsule once daily, tamsulosin 0.4 capsule once daily, vitamin D3 25 micrograms (mcg) once daily, metoprolol 150 mg once daily, simvastatin 20 mg 1 tablet once daily, lidocaine ointment 5 percent (%), oxycodone/acetaminophen 5mg/325 mg 1 tablet three times daily as needed,	01880		

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01880	Continued From page 51 acetaminophen 325 2 tablets every six hours as needed - not to exceed 4000 mg every 24 hours, albuterol inhaler inhale 2 puffs by mouth every 6 hours as needed, cetirizine 10 mg 1 tablet once daily as needed, deep sea saline nasal spray 1 spray into the nose three times daily as needed, docusate sodium 1 capsule twice daily as needed, hydrocortisone 2.5% cream apply to soles of feet as needed, ketoconazole cream 2% apply to feet twice daily as needed, nicotine polarcrilex chewing gum chew 1 piece 5-6 times as needed, petroleum gel apply to dry skin on both feet, sildenafil 100 mg 1 tablet as needed, and Ventolin 90 mcg inhale 2 puffs every six hours as needed. On November 18, 2024, at 9:40 a.m., during a facility tour, the surveyor observed R1's bedroom. On a small table next to the bed was a Ventolin 90 mcg inhaler. R1's medical chart included an Assessment dated November 18, 2024, which indicated the licensee would store all medications and staff would administer medications to R1. R1's Individualized Medication Management Plan lacked documentation the resident could self-administer inhaler medications. On November 19, 2024, at 7:20 a.m., R1 stated there were instructed by their medical doctor to always carry an albuterol inhaler in case of emergency. On November 19, 2024, at 9:42 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for assessing if residents were able to safely store and self-administer medications. CNS-C stated staff were trained to remove mediations from resident rooms if observed.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEATITUDES HOMES LLC	1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01880	Continued From page 52 CNS-C stated they were unaware R1 had the inhaler in their room. On November 20, 2024, at 9:27 a.m., licensed assisted living director (LALD-D) stated if the resident was not assessed as safe and able to self-administer medications, then the licensee should have stored all the medications. The licensee's 7.11 Medication Storage policy dated November 11, 2021 indicated the licensee would keep medications locked and stored per manufactures directions, and only allow authorized staff access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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01910	Continued From page 53 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 the identification of the personnel involved in the medication disposition for one of one discharged 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, 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). R4 was discharged from the facility on February 29, 2024. R4's medication administration record (MAR) dated February 1, 2024, through February 29, 2024, indicated R4 received the following medications: diphenhydramine 25 milligram (mg) two capsules once daily, fluticasone nasal spray 40 micrograms (mcg) one spray in each nostril twice daily, gabapentin 300 mg 1 capsule three times daily, lurasidone 40 mg 1 tablet once daily, ampheta dextro 20 mg 1 tablet as needed, clindamycin gel 1 percent (5) apply to affected area topically once daily, clonidine 0.1 mg 1 table as needed, naloxone 4 mg use one spray in one nostril as needed, Ventolin 90 mcg inhale 1-2	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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01910	Continued From page 54 puffs as needed, and Vyanse 20 mg 1 capsule as needed. R4's resident record contained an undated document titled Discharged/Transfer Summary. The documented lacked identifcation of the individuals involved with the medication disposition upon discharge. On November 20, 2024, at 10:04 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for completing the medication disposition for R4. CNS-C stated the medication disposition should have contained a medication count of each medication and a signature from the registered nurse and the receiving person. CNS-C stated R4 notified the licensee they were discharging on February 29, 2024. CNS-C stated R4 became verbally aggressive toward staff and police were contacted so they were not able to complete the medication disposition. The surveyor requested a copy of the documentation pertaining to the stated situation. R4's Progress note dated December 1, 2023, through November 21, 2024, indicated R4 discharged on February 29, 2024, and R4 took their medications. The note lacked a medication count or information about who conducted the count, and contained no documentation that police were called to the assisted living facility. On November 21, 2024, at 7:53 a.m., licensed assisted living director (LALD)-D stated the registered nurse (RN) was responsible for completing the medication disposition. LALD-D stated the medication count should have been completed at discharge. LALD-D stated if it's not documented, it's not done. LALD-D stated the situation should not have occurred.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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01910	Continued From page 55 The licensee's 7.23 Medication Disposal policy dated October 11, 2021, indicated upon discharge of a resident, the licensee would record the medication name, strength, prescription number, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee staff imposed a restriction which limited the rights of one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37087	A. BUILDING: _____ B. WING _____	11/21/2024

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02290	Continued From page 56 The findings include: On November 19, 2024, at 7:47 a.m., the surveyor observed house manager (HM)-B and R2 in the kitchen of the facility. HM-B stated to R2 they were not allowed to make coffee several times, and if R2 wanted coffee they had to ask a staff member. On November 19, 2024, at 9:04 a.m., HM-B stated they did not want R2 to make coffee as there was spillage from the coffee machine. HM-B stated they were trained by their supervisor to inform residents they were not allowed to make coffee. R2's assessment dated November 18, 2024, lacked documentation to indicate R2 was not safe to make coffee in the kitchen. On November 19, 2024, at 9:53 a.m., clinical nurse supervisor (CNS)-C stated R2 was not assessed to be unsafe making coffee, and there was no reason for placing that restriction on R2. On November 20, 2024, at 9:11 a.m., licensed assisted living director (LALD)-D stated there was no reason for staff to place the restriction on R2. LALD-D stated the only reason that restriction could be placed on R2 was if the registered nurse (RN) had assessed R2 unsafe to make coffee. LALD-D stated HM-B should not have prevented R2 from making coffee and was unsure why HM-B made that statement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Type: Full
Date: *11/18/24*
Time: 14:05:36
Report: 8058241292

Food and Beverage Establishment Inspection Report

Location:
Beatitudes Homes Llc
1609 84th Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0038515
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635019192
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CUCUMBER
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MUSHROOM
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR KEITH LANGLEY

GINIKA OSAKWE ASST. LIVING DIRECTOR

RESIDENTIAL HOME WITH NON-COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *11/18/24*
Time: 14:05:36
Report: 8058241292
Beatitudes Homes Llc

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 8058241292 of 11/18/24.

Certified Food Protection Manager: SONIE PADMORE

Certification Number: 119401 Expires: 09/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
SONIE PADMORE
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us