



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

July 1, 2025

Licensee  
Bethel Haven Care  
31274 Julliard Street Northeast  
North Branch, MN 55056

RE: Project Number(s) SL30796016

Dear Licensee:

On May 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 30, 2025. 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,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor  
State Evaluation Team  
Email: Kelly.Thorson@state.mn.us  
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

March 6, 2025

Licensee

Bethel Haven Care

31274 Julliard Street Northeast

North Branch, MN 55056

RE: Project Number(s) SL30796016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 30, 2025, 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:



**0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00**

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00**

**1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

**1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$12,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), 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.

#### **INFORMAL CONFERENCE**

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Bethel Haven Care. Please contact Kelly Thorson at 320-223-7336 on or before Tuesday, March 11, 2025, to schedule the conference call.

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](mailto: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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: [kelly.thorson@state.mn.us](mailto:kelly.thorson@state.mn.us)

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |
|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 000                                                 | <p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL30796016-0</p> <p>On January 27, 2025, through January 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 resident(s); 10 receiving services under the Assisted Living Facility license.</p> <p>Immediate orders for correction were identified on January 28, 2025, issued for SL30796016-0, tags identified 0775 and 1290.</p> <p>During the course of the survey, the licensee took action to mitigate the imminent risk for tag identification 0775. Noncompliance remained and the scope and level remain unchanged.</p> <p>An Immediate order for correction was identified on January 29, 2025, issued for SL30796016-0, tag identified 0470.</p> <p>An Immediate order for correction was identified</p> | 0 000                                                                                   | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p> |  |                                              |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                        | Continued From page 1<br><br>on January 29, 2025, issued for SL30796016-0,<br>tag identified 1950.<br><br>During the course of the survey, the licensee<br>failed to take action to mitigate the imminent risk<br>identified in the immediate orders tag<br>identification 1290, 0470, and 1950.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 000                                                                                           |                                                                                                                          |  |                                                        |
| 0 340<br>SS=F                                                | <b>144G.30 Subd. 5</b> Correction orders<br><br>(a) A correction order may be issued whenever<br>the commissioner finds upon survey or during a<br>complaint investigation that a facility, a<br>managerial official, an agent of the facility, or staff<br>of the facility is not in compliance with this<br>chapter. The correction order shall cite the<br>specific statute and document areas of<br>noncompliance and the time allowed for<br>correction.<br>(b) The commissioner shall mail or email copies<br>of any correction order to the facility within 30<br>calendar days after the survey exit date. A copy of<br>each correction order and copies of any<br>documentation supplied to the commissioner<br>shall be kept on file by the facility and public<br>documents shall be made available for viewing by<br>any person upon request. Copies may be kept<br>electronically.<br>(c) By the correction order date, the facility must:<br>(1) document in the facility's records any action<br>taken to comply with the correction order. The<br>commissioner may request a copy of this<br>documentation and the facility's action to respond<br>to the correction order in future surveys, upon a<br>complaint investigation, and as otherwise<br>needed; and<br><br>This MN Requirement is not met as evidenced<br>by: | 0 340                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 340                                                        | <p>Continued From page 2</p> <p>Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0680, 0810, 1730, 1940, and 1970) for a survey completed on August 26, 2022. This had the potential to affect all residents, staff and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on January 27, 2025, at 10:25 a.m., licensed assisted living director (LALD)- A, clinical nurse supervisor (CNS)-B and owner (O)-C all stated they were familiar with current minimum assisted living requirements.</p> <p>The licensee provided an undated Plan of Correction, which consisted of three pages including the following information:<br/>-0680: Develop Emergency Preparedness Plan - Documentation of action EP completed - date completed October 16, 2022;<br/>-0810: Develop fire safety and evacuation plans and provide training to residents, employees for fire safety and evacuation, and conduct required employee evacuation drills - EP completed, and staff being trained during employee orientation - date completed October 16, 2022, and November 21, 2022;<br/>- 1730: Individualized medication management</p> | 0 340                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 340                                                        | <p>Continued From page 3</p> <p>plan - admission assessment was reentered into electronic charting system so that the individual medication treatment plan report can be generated from the system - dated completed October 8, 2022;</p> <p>- 1940: Develop and implement a treatment or therapy management plan to include all required content - date completed October 15, 2022; and</p> <p>- 1970 Obtain provider orders - Fax copy of prescription order received from pharmacy and filed in resident's folder - dated completed August 29, 2022.</p> <p>The licensee lacked documentation to indicate correction orders previously cited on August 26, 2022, were in full compliance with assisted living care statutes.</p> <p>On January 30, 2025, at 11:30 a.m., LALD-A stated they had fixed all of the tags they had received from the previous survey and thought the fixes they made were meeting the assisted living statutes.</p> <p>On January 30, 2025, the survey concluded, and correction orders 0680, 0810, 1730, 1940, and 1970 were reissued.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 340                                                                                           |                                                                                                                          |  |                                                     |
| 0 420<br>SS=F                                                | <p><b>144G.40</b> Subdivision 1 Responsibility for housing and services</p> <p>The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 420                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 420                                                        | <p>Continued From page 4</p> <p>Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all residents.</p> <p>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).</p> <p>The findings include:</p> <p>During the survey from January 27, 2025, through January 30, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents.</p> <p>The licensee had an assisted living license, effective March 1, 2024.</p> <p>The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that,</p> | 0 420                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 420                                                        | <p>Continued From page 5</p> <p>as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract."</p> <p>Another checkmark was noted on the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required."</p> <p>Page six was electronically signed by the owner/authorized agent on December 21, 2022.</p> <p>As a result of this survey, the following orders were issued under 0340, 0470, 0500, 0510, 0660, 0680, 0775, 0780, 0800, 0810, 1060, 1290, 1370, 1380, 1470, 1500, 1530, 1620, 1730, 1790, 1880, 1940, 1950, 1960, 1970, and 2310, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 420                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                        | Continued From page 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 470                                                                  |                                                                                                                          |  |                                                     |
| 0 470<br>SS=I                                                | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure they had one or more persons available 24 hours per day, seven days per week, who were awake and responsible for responding to the requests of residents for assistance with health or safety needs. This had the potential to affect all | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                        | <p>Continued From page 7</p> <p>residents.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 27, 2025, at 10:10 a.m., licensed assisted living director (LALD)-A escorted the surveyor into a room upstairs to use while onsite for survey. The surveyor observed the room, it contained a desk, two chairs, file cabinet, storage cabinet, bed, and a closet space used for storage. The surveyor observed a backpack and a second bag on top of the bed. There was also a cell phone attached to a charger plugged into the wall outlet sitting on a chair beside the bed. The surveyor observed a sign posted on the wall beside the bed that read, "Overnights Please be sure all cleaning tasks/meds are done before heading to bed. Please be awake no later than 5AM to complete scheduled med passes. Be sure O2 tanks are being filled throughout the night."</p> <p>On January 27, 2025, at 2:10 p.m., ULP-G entered the room and stated she was just grabbing her cell phone, unplugged the phone, and left the room.</p> <p>On January 28, 2025, at 9:04 a.m., during a tour of the facility with the engineer, director of maintenance (DM)-D stated the room is not a resident bedroom and thinks the bed is for</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                        | <p>Continued From page 8</p> <p>overnight staff to use but would need to check with the LALD-A to confirm.</p> <p>On January 28, 2025, at 9:20 a.m., owner (O)-C stated the staff sometimes sleep on the overnight shift if they are working a double due to staffing issues and she thought the statutes allow for assisted living facilities with a capacity under 10 to allow staff to sleep overnight as long as they are in the same building and can assist is a resident has any needs.</p> <p>On January 28, 2025, at 10:00 a.m., LALD-A stated he thought staff were able to sleep on the overnight shift because he had been looking at an old copy of the statues given to him by the previous owners and did not realize it was old, but he could not deny that occasionally the overnight staff sleep for a few hours sometimes.</p> <p>The facility staffing plan reviewed on September 16, 2024, indicated 7 a.m. -5 p.m. there will be 2 staff members onsite. 5 p.m. - 7 a.m. there will be 1 staff member at the facility.</p> <p>The licensee's Staffing, Direct-Care Staffing Plan &amp; Daily Schedule policy dated February 1, 2022, indicated one or more persons will be available 24 hours per day, seven days per week who are responsible for responding to the requests of residence for assistance for health and safety needs. Persons will be be:</p> <ul style="list-style-type: none"><li>- Awake</li><li>- Located in:<ul style="list-style-type: none"><li>- The same building or</li><li>- An attached building</li><li>- On a contiguous campus within the facility in order to respond within a reasonable amount of time</li></ul></li><li>- Capable of communicating with residents</li></ul> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                        | Continued From page 9<br><br>- Capable of summoning appropriate assistance<br>- Capable of following directions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 470                                                                                           |                                                                                                                          |  |                                                        |
| 0 500<br>SS=F                                                | 144G.41 Subd. 2 Policies and procedures<br><br>Each assisted living facility must have policies<br>and procedures in place to address the following<br>and keep them current:<br>(1) requirements in section 626.557, reporting of<br>maltreatment of vulnerable adults;<br>(2) conducting and handling background studies<br>on employees;<br>(3) orientation, training, and competency<br>evaluations of staff, and a process for evaluating<br>staff performance;<br>(4) handling complaints regarding staff or<br>services provided by staff;<br>(5) conducting initial evaluations of residents'<br>needs and the providers' ability to provide those<br>services;<br>(6) conducting initial and ongoing resident<br>evaluations and assessments of resident needs,<br>including assessments by a registered nurse or<br>appropriate licensed health professional, and how<br>changes in a resident's condition are identified,<br>managed, and communicated to staff and other<br>health care providers as appropriate;<br>(7) orientation to and implementation of the<br>assisted living bill of rights;<br>(8) infection control practices;<br>(9) reminders for medications, treatments, or<br>exercises, if provided;<br>(10) conducting appropriate screenings, or<br>documentation of prior screenings, to show that<br>staff are free of tuberculosis, consistent with | 0 500                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 500                                                        | <p>Continued From page 10</p> <p>current United States Centers for Disease Control and Prevention standards;</p> <p>(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;</p> <p>(12) medication and treatment management;</p> <p>(13) delegation of tasks by registered nurses or licensed health professionals;</p> <p>(14) supervision of registered nurses and licensed health professionals; and</p> <p>(15) supervision of unlicensed personnel performing delegated tasks.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures.</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on January 27, 2025, at 10:25 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and owner (O)-C stated they were aware of the current minimum assisted living regulations and requirements of 144G.41.</p> | 0 500                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 500                                                        | <p>Continued From page 11</p> <p>During the survey from January 27, 2025, through January 30, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents.</p> <p>The licensee failed to implement policies and procedures to address the following:</p> <p>Conducting and handling background studies on employees</p> <ul style="list-style-type: none"><li>- Refer to licensing order 1290, at MN Statute 144G.60 Subd. 1. The licensee failed to ensure current employee records contained a background study clearance letter for one of 11 employees (unlicensed personnel (ULP)-G). In addition, the licensee failed to affiliate employee background studies with the correct healthcare facility identification (HFID) for three of 11 employees (unlicensed personnel/housing manager (ULP/HM-F), director of maintenance DM-D, and ULP-I). In addition, the licensee failed to ensure COVID expired background studies were completed for one of eleven employees (ULP-H).</li></ul> <p>Orientation, training, and competency evaluations of staff, and a process for evaluating staff performance</p> <ul style="list-style-type: none"><li>- Refer to licensing order 1370 and 1380 at MN Statute 144G.61. Subd. 2. The licensee failed to ensure required training was completed for two of two employees (unlicensed personnel (ULP)-H and ULP-J).</li><li>- Refer to licensing order 1470 at MN Statute 144G.63. Subd. 2. The licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations</li></ul> | 0 500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 500                                                        | <p>Continued From page 12</p> <p>prior to providing services for four of four employees (unlicensed personnel/housing manager (ULP/HM)-F, unlicensed personnel (ULP)-E, ULP-H, and ULP-J).</p> <p>-Refer to licensing order 1500, at MN Statute 144G.63 Subd. 5. The licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-H.</p> <p>-Refer to licensing order 1530, at MN Statute 144G.64 (a) (1-2). The licensee failed to ensure all employees received eight (8) hours of initial dementia care training within the first 160 working hours of employment for two of two employees, (unlicensed personnel/housing manager (ULP/HM)-F and unlicensed personnel (ULP)-J); and two (2) hours of annual dementia care training for direct care employees as required for two of two employees, (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-H).</p> <p>-Refer to licensing order 1790, at MN Statute 144G.71 Subd. 10. (a; 2-4) (b). The licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (unlicensed personnel/housing manager (ULP/HM)-F).</p> <p>Conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other</p> | 0 500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 500                                                        | <p>Continued From page 13</p> <p>health care providers as appropriate.<br/>-Refer to licensing order 1620, at MN Statute 144G.70 Subd. 2. The licensee failed to ensure a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for three of three residents (R2, R3, and R5).</p> <p>Orientation to and implementation of the assisted living bill of rights.<br/>-Refer to licensing order 2310, at MN Statute 144G.91 Subd. 4. The licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to secure oxygen tank storage for one of one resident (R4).</p> <p>Infection control practices<br/>- Refer to licensing order 0510 at MN Statute 144G.41 Subd. 3. The licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-E) observed during medication administration.</p> <p>Conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards<br/>- Refer to licensing order 0660 at MN Statute 144G.42. Subd. 9. The licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were</p> | 0 500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 500                                                        | <p>Continued From page 14</p> <p>completed and documented for two of four employees, (unlicensed personnel (ULP)-H and ULP-J).</p> <p>Medication and treatment management<br/>- Refer to licensing order 1730 at MN Statute 144G.71 Subd. 5. The licensee failed to develop an individual medication management plan to include all required content for three of three residents (R2, R3, and R4).</p> <p>-Refer to licensing order 1940, at MN Statute 144G.72 Subd. 3. The licensee failed to ensure the registered nurse (RN) developed and maintained a current individualized treatment and therapy record for two of two residents (R2 and R3) who had ordered treatments.</p> <p>-Refer to licensing order 1970, at MN Statute 144G.72 Subd. 6. The licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's two residents (R2 and R3) receiving treatments.</p> <p>Delegation of tasks by registered nurses or licensed health professionals<br/>- Refer to licensing order 1950 at MN Statute 144G.72 Subd. 4. The licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform treatments and the ULP demonstrated competency back to the registered nurse (RN) for three of three employees (unlicensed personnel/housing manager (ULP/HM)-F, and unlicensed personnel (ULP)-H and ULP-J).</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p> | 0 500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 500                                                 | Continued From page 15<br><br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 500                                                                                   |                                                                                                                          |  |                                              |
| 0 510<br>SS=D                                         | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-E) observed during medication administration.<br><br>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). | 0 510                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                        | <p>Continued From page 16</p> <p>The findings include:</p> <p>On January 28, 2025, at 8:30 a.m., ULP-E was observed performing medication administration for R2. The surveyor did not observe ULP-E perform hand hygiene prior to start of medication administration. ULP-E donned (applied) gloves and proceeded to verify R2's oral medications and placed the oral medications into a medication cup. ULP-E verified R2's Ozempic (an injectable diabetes medication), attached the needle to the pen, and dialed the pen to the correct dose. ULP-E gathered all medications and entered R2's bedroom. ULP-E administered R2's oral medications and then injected the Ozempic into R2's abdomen. ULP-E failed to sanitize R2's abdomen with an alcohol wipe prior to injecting the medication. ULP-E exited R2's bedroom and proceeded to dispose of the needle in the sharps container, doffed (removed) the gloves, and placed them in the waste container. ULP-E charted the medications in the electronic medication administration record (EMAR) and stated he was done. ULP-E failed to perform hand hygiene after completing the service.</p> <p>On January 28, 2025, at 8:40 a.m., ULP-E stated he was trained by the registered nurse (RN) on medication administration. ULP-E stated he forgot to perform hand hygiene before putting on the gloves and after he took them off because he was nervous with the surveyor observing him. ULP-E stated he normally uses an alcohol wipe to clean the resident's skin before injecting a medication but he was nervous and so he forgot.</p> <p>On January 28, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she would expect the ULP's to wash or sanitize their hands prior to donning gloves and after doffing them and this is</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                        | <p>Continued From page 17</p> <p>standard infection control practice, and the staff should know this. CNS-B also stated she would expect the ULP's to clean the resident's skin with an alcohol wipe prior to injecting medication and if this was not done it would be a breach in infection control standards.</p> <p>The manufacturer's instructions for Ozempic dated October 2023, indicated to choose your injection site and wipe the skin with an alcohol swab. Let the injections site dry before you inject your dose.</p> <p>The licensee's Hand Hygiene policy dated February 5, 2022, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing.</p> <p>The licensee's Procedure for using Gloves policy dated February 5, 2022, indicated procedure:</p> <ul style="list-style-type: none"><li>- Wash hands;</li><li>- Apply gloves to both hands;</li><li>- Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the resident, then change the gloves (washing hands before putting on new gloves before starting the next task);</li><li>- Place any contaminated materials in proper receptacle;</li><li>- Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tucked finger and side cuff of remaining glove and pull off, turning inside out with first glove inside the second glove;</li><li>- Dispose of used glove and proper receptacle; and</li><li>- Rewash hands.</li></ul> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                        | Continued From page 18<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 510                                                                                           |                                                                                                                          |  |                                                     |
| 0 660<br>SS=F                                                | <b>144G.42 Subd. 9 Tuberculosis prevention and control</b><br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of four employees, (unlicensed personnel (ULP)-H and ULP-J).<br><br>This practice resulted in a level two violation (a | 0 660                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 660                                                        | <p>Continued From page 19</p> <p>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).</p> <p>The findings include:</p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> <p>ULP-H's employee record lacked evidence of a TB baseline blood/skin test screening that had been completed at the time of hire.</p> <p>On January 29, 2025, at 9:34 a.m., licensed assisted living director (LALD)-A stated he was unable to locate the TB test results for ULP-H because he started in 2021. LALD-A stated he knows ULP-H had the TB test completed at time of hire, but they realized the test results were missing from the employee record last evening and started the two-step TB skin test process again when ULP-H worked.</p> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 12:15 p.m., the surveyor observed ULP-J prepare and serve lunch to several residents of the facility.</p> <p>ULP-J's employee record contained a negative TB baseline skin test screening dated June 24,</p> | 0 660                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                        | <p>Continued From page 20</p> <p>2024. However, ULP-J's record lacked a second negative TB baseline skin test screening.</p> <p>On January 30, 2025, at 1:45 p.m., LALD-A stated UP-J is missing the second step of the TB skin test and is unable to find it in her employee record so it must not have been done.</p> <p>The licensee's undated TB Prevention and Control policy indicated this facility will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The Minnesota Department of Health guidelines: Regulations for Tuberculosis Control in Minnesota Health Care Settings will be followed. At time of hire and prior to any contact with residents, all assisted living employees and all volunteers will be screened for Tuberculosis.</p> <ul style="list-style-type: none"><li>- Prior to contact with residents, the RN will review TB symptoms with each new assisted living employee and with any volunteers having direct resident contact.</li><li>- Prior to contact with residents, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold-InTube, TSPOT ®.TB) will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. Individuals who have been vaccinated with Bacillus Calmette-Guerin (BCG) vaccine are not exempt from tuberculin skin testing.</li></ul> <p>The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated the following general principals:</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 660                                                 | <p>Continued From page 21</p> <ul style="list-style-type: none"><li>- There are two methods available to screen for TB infection: the tuberculin skin test (TST) and the Interferon Gamma Release Assay (IGRA). Information about these methods is available at <a href="http://www.health.state.mn.us/divs/idepc/diseases/tb/tst.html">www.health.state.mn.us/divs/idepc/diseases/tb/tst.html</a> and <a href="http://www.health.state.mn.us/divs/idepc/diseases/tb/bloodtests.html">www.health.state.mn.us/divs/idepc/diseases/tb/bloodtests.html</a>.</li><li>- All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record.</li><li>- TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative).</li><li>- IGRA documentation should include the date of the test (i.e., month, day, year), the qualitative results (i.e., positive, negative, indeterminate or borderline) and the quantitative assay (i.e., Nil, TB and Mitogen concentrations or spot counts). Indeterminate or borderline results indicate an uncertain likelihood of M. tuberculosis infection and should be further evaluated by a physician.</li><li>- HCWs should be encouraged to keep copies of the results of their TB screening for future use.</li><li>- Disregard a HCW's history of BCG vaccination when administering and interpreting a TST.</li><li>- It is the responsibility of the infection control team to ensure that written procedures are in place and are followed by staff to ensure that employees are free of infectious TB disease before beginning employment.</li></ul> <p>The MDH resources and frequently asked questions, updated December 13, 2024, indicated a chest x-ray alone is not acceptable documentation. You either need:</p> <ul style="list-style-type: none"><li>- Documentation of a positive two-step TST or IGRA test, and</li><li>- A chest x-ray with provider evaluation after that</li></ul> | 0 660                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 660                                                 | Continued From page 22<br><br>date or<br>- Documentation of refusal of both the two-step<br>TST and IGRA<br>- Followed by a new chest X-ray and provider<br>evaluation.<br>If the health care worker had a positive TB test<br>result, and they only have the chest X-ray but no<br>other test documentation, then they need to take<br>a new TB test. If the result is positive, a new<br>chest X-ray needs to be completed. The chest<br>X-ray needs to be done within 90 days of the<br>positive test date or dated any time after the<br>positive test date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                 | 0 660                                                                                   |                                                                                                                          |  |                                              |
| 0 680<br>SS=F                                         | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff | 0 680                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                        | <p>Continued From page 23</p> <p>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.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On January 27, 2025, at 12:00 p.m., owner (O)-C provided the surveyor with a binder that contained the emergency preparedness manual and indicated the contents were the licensee's EP plan.</p> <p>The licensee's emergency preparedness plan (EPP), dated October 16, 2022, lacked the required content:</p> <ul style="list-style-type: none"><li>- annual review;</li><li>- documentation of the facility risk assessment;</li><li>- missing resident quarterly review;</li></ul> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 680                                                 | Continued From page 24<br><br>- description of the population served by licensee;<br>- a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations;<br>- the development of policies/procedures to address:<br>- subsistence needs for staff and residents;<br>- procedures for tracking staff and residents;<br>- procedures including evacuation;<br>- procedures for sheltering;<br>- procedures for medical documents;<br>- use of volunteers;<br>- arrangement with other facilities; and<br>- roles under a waiver declared by Secretary.<br>- development of a written communication plan;<br>- names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers;<br>- emergency officials contact information;<br>- primary and alternate means for communication;<br>- methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care;<br>- means to providing information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee;<br>- method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives;<br>- develop and maintain EP training and testing program; and<br>- exercises to test the EPP at least twice per year, including unannounced drills using the EPP.<br><br>On January 28, 2025, at 3:15 p.m., O-C stated | 0 680                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 680                                                 | <p>Continued From page 25</p> <p>they realize the emergency preparedness plan was missing almost all of the required information.</p> <p>On January 28, 2025, at 3:20 p.m., licensed assisted living director (LALD)-A stated they had been trying to find someone to help them with the EPP but have not been able to find anyone and they have not updated or developed a new EPP for this facility.</p> <p>The licensee's Emergency and Disaster Preparedness policy dated February 5, 2022, indicated the facility will be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning. The emergency operations plan, communications plan, and the policies and procedures will be reviewed and updated at least annually.</p> <p>The licensee's Missing Resident policy dated October 1, 2022, indicated the assisted living director and clinical nurse supervisor will review the missing resident plan at least quarterly and document any changes to the plan..</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 680                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                                                                                                                                                                                             |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                       |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                                                                                                                                                                                             |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                    |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 775                                                        | Continued From page 26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 775                                                                  |                                                                                                                                                                                                                                                                                             |  |                                                     |
| 0 775<br>SS=I                                                | <p><b>144G.45 Subd. 2. (a) Fire protection and physical environment</b></p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On a facility tour on January 28, 2025, between 8:30 a.m. and 12:30 p.m. with maintenance (DM)-D and the licensed assisted living director (LALD)-A, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms.</p> <p>Second level resident sleeping room 11 emergency escape and rescue clear window opening measurements are W24" X H22" X SH18", resident sleeping room 13, W19" X H14" X SH26", first level resident sleeping room 5, W19" X H40" X SH37". The windows do not meet the 20 inches minimum requirements for width</p> | 0 775                                                                  | <p>An immediate correction order was identified on January 28, 2025, issued for SL30796016-0, tag identification 0775.</p> <p>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.</p> |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 775                                                        | <p>Continued From page 27</p> <p>and some do not meet the 648 square inch total. The windows were measured by the surveyor with the DM-D and LALD-A present.</p> <p>At least one compliant emergency escape and rescue opening is required within each resident sleeping room.</p> <p>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches.</p> <p>These deficient conditions were visually verified by DM-D and LALD-A accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings.</p> <p>TIME PERIOD FOR CORRECTION: Immediate.</p> <p>Additionally on the facility tour on January 28, 2025, between 8:30 a.m. and 12:30 a.m. with maintenance (DM)-D and the licensed assisted living director (LALD)-A, the surveyor observed the following conditions:</p> <p>GUARDS:</p> <p>The surveyor observed that the area next to the handrail on the upper level was open.</p> <p>The surveyor explained to DM-D and LALD-A this area shall be guarded to prevent anyone accessing the area.</p> <p>SMOKE ALARMS:</p> | 0 775                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 775                                                        | <p>Continued From page 28</p> <p>The surveyor observed that there was not a smoke alarm present outside resident room 5. Also, the DM-D checked a few smoke alarms and they were over 10 years old from date of manufacture.</p> <p>Provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms, 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.</p> <p>All smoke alarms over 10 years old from date of manufacture shall be replaced with like type alarms.</p> <p>EXTENSION CORD:</p> <p>The surveyor observed an orange extension cord in resident room 5 connected to a coffee maker/fan/TV.</p> <p>The surveyor explained to the DM-D and LALD-A that electrical cords shall not be routed through walls/doors and shall not be used for permanent use.</p> <p>LINT:</p> <p>The surveyor observed an excessive level of lint and clothing articles behind the clothes dryer on the main level. So much that the dryer vent connection could not be verified.</p> <p>The surveyor explained to the DM-D and LALD-A that the area behind the clothes dryer shall be</p> | 0 775                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 775                                                        | Continued From page 29<br><br>cleaned periodically.<br><br>MEANS OF EGRESS:<br><br>The surveyor observed a metal ramp from the lower level to the intermediate level. This ramp is the blocking path of egress, stairwell from the upper level.<br><br>The surveyor also observed in resident rooms 6 and 8 that there were items blocking the emergency escape windows.<br><br>The surveyor explained to the DM-D and LALD-A that the metal ramp cannot block the path of egress and that the emergency escape windows shall be accessible all the time.<br><br>The deficient conditions were visually verified by DM-D and LALD-A accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 775                                                                                           |                                                                                                                          |  |                                                        |
| 0 780<br>SS=F                                                | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or                                                                                                                                                | 0 780                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                        | <p>Continued From page 30</p> <p>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</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the facility to actuate. This deficient condition had the ability to affect all staff and residents.</p> <p>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).</p> <p>Findings include:</p> <p>On a facility tour on January 28, 2025, between 8:30 a.m. and 12:30 p.m. with maintenance (DM)-D and the licensed assisted living director (LALD)-A, the surveyor observed that the smoke alarms in resident room 5 and 7 were not interconnected to the smoke alarms in the rest of</p> | 0 780                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 780                                                 | Continued From page 31<br><br>the facility.<br><br>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.<br><br>This deficient condition was visually verified by the DM-D and LALD-A accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days.                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 780                                                                                   |                                                                                                                          |  |                                              |
| 0 800<br>SS=F                                         | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff.<br><br>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 | 0 800                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 800                                                        | <p>Continued From page 32</p> <p>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).</p> <p>The findings include:</p> <p>On a facility tour on January 28, 2025, between 8:30 a.m. and 12:30 p.m. with maintenance (DM)-D and the licensed assisted living director (LALD)-A, the surveyor observed a hole in the gypsum board wall and the base board missing behind the toilet in resident room 3.</p> <p>The surveyor explained to DM-D and LALD-A that the gypsum board and base board shall be replaced and that the facility shall be kept in good repair.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 800                                                                                           |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                | <p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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</p>                                                                                                                                                             | 0 810                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                        | <p>Continued From page 33</p> <p>evacuation.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, the licensee failed to document required fire safety evacuation training for employees and residents and complete the required annual fire drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 potential to affect a large portion or all of the residents).</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                        | <p>Continued From page 34</p> <p>The findings include:</p> <p>A record review and interview were conducted on January 28, 2025, at approximately 11:00 a.m. with maintenance (DM)-D and the licensed assisted living director (LALD)-A on the fire safety and evacuation plan for the facility, training records for the employees and residents and fire drills.</p> <p>FIRE/EVACUATION PLAN:</p> <p>Record review indicated the fire safety and evacuation plan shall be updated. They stated to use the fire extinguisher before calling 911, did not indicate where the residents will be moved to, the building plan was not included in the plan, it did not indicate where they would move the residents to in case of an evacuation and how they would get them to the location. Also, a few of the resident rooms (11 and 13) did not have room numbers posted on the door or in the vicinity. The plan was generic.</p> <p>TRAINING:</p> <p>Record review indicated the licensee failed to complete and document fire safety and evacuation training for the employees at new hire and at least twice a year thereafter and offer the residents the training at least once a year.</p> <p>FIRE DRILLS:</p> <p>Record review indicated the licensee failed to complete and document the required fire drills. The fire drills shall be completed twice a year on each shift and documented.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                        | Continued From page 35<br><br>(21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 01060<br>SS=F                                                | <b>144G.52 Subd. 9 Emergency relocation</b><br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and | 01060                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01060                                                        | <p>Continued From page 36</p> <p>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</p> <p>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R3 was admitted to the licensee and started receiving assisted living services on April 6, 2023.</p> <p>R3's record indicated R3 went to the emergency room on January 10, 2025, after a brief hospitalization for pneumonia.</p> <p>R3's record lacked a written notice including:</p> <ul style="list-style-type: none"><li>- the reason for the relocation</li><li>- the name and contact information for the location to which the resident has been relocated and any new service provider</li><li>- contact information for the Office of Ombudsman for Long-Term Care</li></ul> | 01060                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01060                                                        | <p>Continued From page 37</p> <ul style="list-style-type: none"><li>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and</li><li>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</li><li>- notification to the resident, legal representative, and designated representative</li><li>- notification to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</li></ul> <p>On January 29, 2025, at 9:25 a.m., licensed assisted living director (LALD)-A stated an emergency relocation has not been given to any of the residents, he did not realize that this was for hospitalizations and was not aware of the emergency relocation notification requirements.</p> <p>The licensee's Emergency Relocation policy dated November 30, 2024, indicated in the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ul style="list-style-type: none"><li>- the reason for relocation;</li><li>- the name and contact information for the location to which the resident has been relocated and any new service provider;</li><li>- contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;</li><li>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement</li></ul> | 01060                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01060                                                        | Continued From page 38<br><br>that a return date is not currently known; and<br>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal.<br>The notice required will be delivered as soon as practicable to:<br>- the resident, legal representative, and a designated representative;<br>- for residents who receive home and community-based waiver services under the resident's case manager; and<br>- the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01060                                                                  |                                                                                                                          |  |                                                     |
| 01290<br>SS=I                                                | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction                                                                                                                                                                         | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                        | <p>Continued From page 39</p> <p>does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure current employee records contained a background study clearance letter for one of 11 employees (unlicensed personnel (ULP)-G). In addition, the licensee failed to affiliate employee background studies with the correct healthcare facility identification (HFID) for three of 11 employees (unlicensed personnel/housing manager (ULP/HM-F), director of maintenance DM-D, and ULP-I). In addition, the licensee failed to ensure COVID expired background studies were completed for one of eleven employees (ULP-H). This had the potential to affect all residents living within the facility.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 27, 2025, at 1:30 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's employee roster and discovered four of the facility's employees were not listed as having background studies submitted with the licensee's HFID 30796 and</p> | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01290                                                        | <p>Continued From page 40</p> <p>one of the employees had a COVID expired background study.</p> <p><b>BACKGROUND STUDY CLEARANCE<br/>ULP-G</b></p> <p>On January 27, 2025, at 12:15 p.m., the surveyor observed ULP-G serving the lunch meal to multiple residents of the facility.</p> <p>ULP-G was hired on December 30, 2024, to provide direct care to residents at the facility.</p> <p>ULP-G's employee record lacked a background study clearance letter.</p> <p>On January 28, 2025, at 10:20 a.m., licensed assisted living director (LALD-A) stated ULP-G's background study had been delegated to ULP/HM-F and she must have missed all the steps in the process because ULP-G had gone to do fingerprints and they received the cleared report. However, they did not receive the background study clearance letter because ULP-G did not sign the release of information for the Department of Health Services (DHS) to release the letter and after 14 days the information is deleted.</p> <p><b>BACKGROUND AFFILIATION</b></p> <p><b>ULP/HM-F</b><br/>On January 27, 2025, at 12:15 p.m., the surveyor observed ULP/HM-F serving the lunch meal to residents of the facility.</p> <p>ULP/HM-F was hired on August 12, 2024, to provide direct care to residents at the facility.</p> <p>ULP/HM-F's employee record contained a</p> | 01290                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                        | <p>Continued From page 41</p> <p>cleared background study dated August 12, 2024, affiliated with HFID 40189 for a sister facility, however, ULP/HM-F's employee record lacked documentation of a cleared background study with HFID 30796.</p> <p>DM-D<br/>On January 28, 2025, at 8:50 a.m., the surveyor observed DM-D assisting the Minnesota Department of Health (MDH) engineer with a tour and inspection of the facility.</p> <p>DM-D was hired on December 28, 2024, to provide maintenance services for the facility.</p> <p>DM-D's employee record contained a cleared background study dated December 28, 2024, affiliated with HFID 40189 for a sister facility, however, DM-D's employee record lacked documentation of a cleared background study with HFID 30796.</p> <p>ULP-I<br/>ULP-I was hired on October 14, 2024, to provide direct care services to the residents at the facility.</p> <p>ULP-I's employee record contained a cleared background study dated October 14, 2024, affiliated with HFID 40189 for a sister facility, however, ULP-I's employee record lacked documentation of a cleared background study with HFID 30796.</p> <p>On January 28, 2025, at 10:20 a.m., LALD-A stated ULP-HM-F, DM-D, and ULP-I were affiliated with another facility they own but he has not affiliated them with this facility HFID because he is unsure how to complete this in the system and will need to call them to get these employees affiliated with this HFID.</p> | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01290                                                        | <p>Continued From page 42</p> <p><b>COVID EXPIRED BACKGROUND STUDY</b></p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to provide direct care services to the residents at the facility.</p> <p>The current employee schedule dated December 29, 2024, through January 27, 2025, indicated ULP-H worked without direct supervision on December 31, 2024, January 1, 2, 4, 6, 7, 8, 9, 14, 16, 18, 22, and 23, 2025.</p> <p>ULP-H had a COVID-19 background study, which expired on December 31, 2022; an updated background study had not been submitted for ULP-H.</p> <p>The licensee's Background Checks policy dated February 21, 2022, indicated employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section144.057 in may be disqualified under chapter 245C. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.</p> <p>Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and</p> | 01290                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                        | Continued From page 43<br><br>safety of the persons served by the program.<br>Direct Contact Services - Providing face-to-face<br>care, training, supervision, counseling,<br>consultation, or medication assistance to persons<br>served by the entity.<br><br>Supervision defined in, NETStudy 2.0 System<br>User Manual Updated July 7, 2023, page 53:<br>Supervision Status Study subjects must be under<br>continuous, direct supervision until the study<br>subject is determined eligible of until the entity is<br>notified by DHS that the study subject may<br>provide unsupervised services while the<br>background study is being completed. The<br>supervision status is shown in the "Supervision<br>Required" column for convenience. However,<br>programs are instructed to rely on background<br>study notices for supervision status and other<br>background study determination information.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 01290                                                                                           |                                                                                                                          |  |                                                     |
| 01370<br>SS=F                                                | 144G.61 Subd. 2 (a) Training and evaluation of<br>unlicensed personn<br><br>(a) Training and competency evaluations for all<br>unlicensed personnel must include the following:<br>(1) documentation requirements for all services<br>provided;<br>(2) reports of changes in the resident's condition<br>to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne<br>pathogens;<br>(4) maintenance of a clean and safe<br>environment;<br>(5) appropriate and safe techniques in personal<br>hygiene and grooming, including:                                                                                                                                                                                                                                                                                                                                                                                                                             | 01370                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01370                                                        | <p>Continued From page 44</p> <p>(i) hair care and bathing;<br/>(ii) care of teeth, gums, and oral prosthetic devices;<br/>(iii) care and use of hearing aids; and<br/>(iv) dressing and assisting with toileting;<br/>(6) training on the prevention of falls;<br/>(7) standby assistance techniques and how to perform them;<br/>(8) medication, exercise, and treatment reminders;<br/>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br/>(10) preparation of modified diets as ordered by a licensed health professional;<br/>(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;<br/>(12) awareness of confidentiality and privacy;<br/>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br/>(14) procedures to use in handling various emergency situations; and<br/>(15) awareness of commonly used health technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure required training was completed for two of two employees (unlicensed personnel (ULP)-H and ULP-J).</p> <p>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</p> | 01370                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01370                                                        | <p>Continued From page 45</p> <p>or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> <p>ULP-H's employee record lacked documentation of the following required training to be completed by ULP:</p> <ul style="list-style-type: none"><li>- documentation requirements for all services provided;</li><li>- maintenance of a clean and safe environment;</li><li>- training on the prevention of falls for providers working with the elderly or individuals at risk of falls;</li><li>- medication, exercise, and treatment reminders;</li><li>- basic nutrition, meal preparation, food safety, and assistance with eating;</li><li>- preparation of modified diets as ordered by a licensed health professional;</li><li>- understanding appropriate boundaries between staff and residents and the resident's family;</li><li>- procedures to utilize in handling various emergency situations; and</li><li>- awareness of commonly used health technology equipment and assistive devices.</li></ul> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 12:15 p.m., the surveyor observed ULP-J prepare and serve lunch to several residents of the facility.</p> <p>ULP-J's employee record lacked documentation</p> | 01370                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01370                                                        | <p>Continued From page 46</p> <p>of the following required training to be completed by ULP:</p> <ul style="list-style-type: none"><li>- basic infection control, including blood-borne pathogens;</li><li>- maintenance of a clean and safe environment;</li><li>- medication, exercise, and treatment reminders;</li></ul> <p>and</p> <ul style="list-style-type: none"><li>- understanding appropriate boundaries between staff and residents and the resident's family.</li></ul> <p>On January 30, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated he does not have any further documentation of training and if it is not in the information supplied, they do not have it. LALD-A stated they had been using some outdated forms for training and some training would be missing for all of the unlicensed staff.</p> <p>The licensee's Assisted Living Orientation- ULP Staff policy dated February 21, 2022, indicated in addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test:</p> <ul style="list-style-type: none"><li>- Person-centered care and service delivery including how they apply to direct support services;</li><li>- Documentation requirements for services provided;</li><li>- Changes of condition;</li><li>- Maintenance of a clean and safe environment;</li><li>- Appropriate and safe techniques in personal hygiene and grooming;</li><li>- Fall prevention;</li><li>- Basic nutrition;</li><li>- Meal preparation;</li><li>- Food safety;</li><li>- Assistance with eating;</li><li>- Preparation of modified diets as ordered by a</li></ul> | 01370                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01370                                                        | Continued From page 47<br><br>licensed health professional;<br>- Communication skills including:<br>-Preserving dignity of the resident<br>-Showing respect for the resident, resident preferences, cultural background, and family;<br>- Confidentiality and privacy;<br>- Appropriate boundaries between staff, residents, and resident families; and<br>- Commonly used health technology equipment and assistive devices.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                          | 01370                                                                  |                                                                                                                          |  |                                                     |
| 01380<br>SS=F                                                | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by: | 01380                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01380                                                        | <p>Continued From page 48</p> <p>Based on observation, interview, and record review, the licensee failed to ensure required training was completed for two of two employees (unlicensed personnel (ULP)-H and ULP-J).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> <p>ULP-H's employee record lacked documentation of the following required training to be completed by ULP:<br/>- recognizing physical, emotional, cognitive, and developmental needs of the resident.</p> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 12:15 p.m., the surveyor observed ULP-J prepare and serve lunch to several residents of the facility.</p> <p>ULP-J's employee record lacked documentation of the following required training to be completed by ULP:<br/>- recognizing physical, emotional, cognitive, and developmental needs of the resident.</p> | 01380                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01380                                                        | <p>Continued From page 49</p> <p>On January 30, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated he does not have any further documentation of training and if it is not in the information supplied, they do not have it. LALD-A stated they had been using some outdated forms for training and some training would be missing for all of the unlicensed staff.</p> <p>The licensee's Assisted Living Orientation- ULP Staff policy dated February 21, 2022, indicated in addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test:</p> <ul style="list-style-type: none"><li>- observing, reporting, and documenting resident status;</li><li>- basic knowledge of body functioning, changes in body functioning, Injuries or other observed changes that must be reported to appropriate personnel; and</li><li>- recognizing physical, emotional, cognitive and developmental needs of the resident.</li></ul> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01380                                                                  |                                                                                                                          |  |                                                     |
| 01470<br>SS=F                                                | <p><b>144G.63 Subd. 2</b> Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p> <p>(1) an overview of this chapter;</p> <p>(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;</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01470                                                 | Continued From page 50<br><br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(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<br>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased | 01470                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                        | <p>Continued From page 51</p> <p>incidence of dementia, falls, hospitalizations, isolation, and depression; or<br/>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for four of four employees (unlicensed personnel/housing manager (ULP/HM)-F, unlicensed personnel (ULP)-E, ULP-H, and ULP-J).</p> <p>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).</p> <p>The findings include:</p> <p>ULP/HM-F<br/>ULP/HM-F was hired on August 12, 2024, to perform direct care services to the licensee's residents.</p> | 01470                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                        | <p>Continued From page 52</p> <p>On January 29, 2025, at 11:15 a.m., the surveyor observed ULP/HM-F prepare R2's peritoneal dialysis machine for her evening dialysis.</p> <p>ULP/HM-F's employee record lacked the following required orientation content:</p> <ul style="list-style-type: none"><li>- handling of emergencies and use of emergency services.</li></ul> <p>ULP-E</p> <p>ULP-E was contracted through a staffing agency on January 13, 2025, to provide direct care services to the licensee's residents.</p> <p>On January 28, 2025, at 8:30 a.m., the surveyor observed ULP-E administer medications to R2.</p> <p>ULP-E's employee record lacked the following required orientation content:</p> <ul style="list-style-type: none"><li>- an overview of the assisted living statutes;</li><li>- policies and procedures related to the provision of assisted living services;</li><li>- handling of emergencies and use of emergency services;</li><li>- compliance with and reporting of the maltreatment of vulnerable adults;</li><li>- the Assisted Living Bill of Rights (AL BOR) and staff responsibilities related to ensuring the exercise and protection of those rights;</li><li>- the principles of person-centered planning and service delivery;</li><li>- handling and reporting of residents' complaints;</li><li>- consumer advocacy services; and</li><li>- a review of the types of assisted living services the employee would be providing.</li></ul> <p>ULP-H</p> <p>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                        | <p>Continued From page 53</p> <p>ULP-H's employee record lacked the following required orientation content:</p> <ul style="list-style-type: none"><li>- an overview of the assisted living statutes;</li><li>- the AL BOR and staff responsibilities related to ensuring the exercise and protection of those rights; and</li><li>- principles of person-centered planning and service delivery.</li></ul> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 12:15 p.m., the surveyor observed ULP-J prepare and serve lunch to several residents of the facility.</p> <p>ULP-J's employee record lacked the following required orientation content:</p> <ul style="list-style-type: none"><li>- the principles of person-centered planning and service delivery.</li></ul> <p>On January 29, 2025, at 5:00 p.m., licensed assisted living director (LALD)-A stated ULP-E does not have any orientation to assisted living in his employee record because he is agency staff, and they thought the agency would be responsible for all of the training records.</p> <p>On January 30, 2025, at 1:45 p.m., LALD-A stated the ULP's are missing orientation topics because they were assigned but not completed and will need to follow up with the staff to have all topics completed.</p> <p>The licensee's Assisted Living and Assisted Living with Memory Care Orientation- All Staff policy dated February 21, 2022, indicated all assisted living employees must complete an orientation to</p> | 01470                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                        | <p>Continued From page 54</p> <p>assisted living facility licensing requirements and regulations before providing services to residents. At minimum, orientation must include the following topics:</p> <ul style="list-style-type: none"><li>- An overview of Minnesota's assisted living law.</li><li>- An introduction and review of agency policies and procedures related to the provision of assisted living services.</li><li>- Emergency and disaster training.</li><li>- The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights.</li><li>- Principles of person-centered planning and service delivery and how they apply to direct support services.</li><li>- Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure.</li><li>- How to report maltreatment of vulnerable adults.</li><li>- Complaint process.</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01470                                                                                           |                                                                                                                          |  |                                                     |
| 01500<br>SS=F                                                | <p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01500                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 |                                                                                                                          |                          |                                              |
|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056                                  |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 01500                                                 | Continued From page 55<br><br>staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or | 01500                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                        | <p>Continued From page 56</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-H.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>CNS-B<br/>CNS-B was hired on December 13, 2016, under the comprehensive home care license and began providing direct care assisted living services to the licensee's resident's and supervision of the licensee's staff on August 1, 2021.</p> <p>CNS-B's record lacked evidence annual training had been completed as required in the following areas:<br/>- reporting maltreatment of vulnerable adults or minors;<br/>- Assisted Living Bill of Rights;</p> | 01500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                        | <p>Continued From page 57</p> <ul style="list-style-type: none"><li>- infection control techniques;</li><li>- effective approaches to use to problem solve when working with a residence challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</li><li>- Review of provider's policies and procedures; and</li><li>- principles of person-centered planning/service delivery.</li></ul> <p>On January 29, 2025, at 3:00 p.m., CNS-B stated she had not completed any of her annual training until after the start of survey this week when she realized it was all due and she had not kept up with it.</p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> <p>ULP-H's record lacked evidence annual training had been completed as required in the following areas:</p> <ul style="list-style-type: none"><li>- reporting maltreatment of vulnerable adults or minors;</li><li>- Assisted Living Bill of Rights;</li><li>- infection control techniques;</li><li>- effective approaches to use to problem solve when working with a residence challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</li><li>- Review of provider's policies and procedures; and</li><li>- principles of person-centered planning/service delivery.</li></ul> <p>On January 30, 2025, at 1:45 p.m., licensed</p> | 01500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01500                                                 | Continued From page 58<br><br>assisted living director (LALD)-A stated annual training had been assigned to ULP-H, but he had not completed any of it and will need to have ULP-H start his annual training. Staff keeping up on their annual training is a problem with all staff.<br><br>The licensee's Assisted Living Annual Training policy dated February 21, 2022, indicated all assisted living employees will complete annual education in the following topics:<br>- reporting of maltreatment of adults;<br>- Assisted Living Bill of Rights and staff responsibility related to ensuring the exercise and protection in the assisted living Bill of Rights;<br>- Infection control techniques used in the home and implementation of infection control standards;<br>- effective approaches for problem solving when working with challenging behaviors;<br>- effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders;<br>- review of policies and procedures relating to the provision of assisted living services and how to implement them;<br>- principles of person-centered planning and service delivery;<br>- how person-centered planning and service delivery applies to direct support services provided by staff; and<br>- emergency and disaster training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500                                                                                   |                                                                                                                          |  |                                              |
| 01530<br>SS=F                                         | 144G.64 TRAINING IN DEMENTIA CARE<br>REQUIRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 01530                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                        | <p>Continued From page 59</p> <p>(a) All assisted living facilities must meet the following training requirements:<br/>(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;<br/>(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 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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure all employees received eight (8) hours of initial dementia care training within the first 160 working hours of employment for two of two employees, (unlicensed personnel/housing manager (ULP/HM)-F and unlicensed personnel (ULP)-J); and two (2) hours of annual dementia care training for direct care employees as required for two of two employees, (clinical nurse supervisor</p> | 01530                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01530                                                        | <p>Continued From page 60</p> <p>(CNS)-B and unlicensed personnel (ULP)-H).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>INITIAL DEMENTIA TRAINING</p> <p>ULP/HM-F</p> <p>ULP/HM-F was hired on August 12, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 11:15 a.m., the surveyor observed ULP/HM-F prepare R2's peritoneal dialysis machine for her evening dialysis.</p> <p>ULP/HM-F's transcript dated January 29, 2025, included the following dementia care training:</p> <ul style="list-style-type: none"><li>- Dementia - Communication - Family Support (0.50 hours) completed September 15, 2024;</li><li>- Dementia - Overview -Other Types of Dementia (0.75 hours) completed September 15, 2024;</li><li>- Dementia - Person-Centered Care (0.75 hours) completed September 17, 2025;</li><li>- Dementia - The Face of Dementia - The Journey (1.00 hour) competed September 17, 2025; and</li><li>- Dementia 1 - Introduction and Overview (1.00 hour) completed September 18, 2025.</li></ul> <p>ULP/HM-F had four (4) hours on initial dementia training completed. ULP/HM-F's employee record</p> | 01530                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                        | <p>Continued From page 61</p> <p>lacked the required eight (8) hours of dementia care training within 160 hours of working for the licensee.</p> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform direct care services to the licensee's residents.</p> <p>On January 29, 2025, at 12:15 p.m., the surveyor observed ULP-J prepare and serve lunch to several residents of the facility.</p> <p>ULP-J had zero (0) hours on initial dementia training completed. ULP-J's employee record lacked the required eight (8) hours of dementia care training within 160 hours of working for the licensee.</p> <p>ANNUAL DEMENTIA TRAINING</p> <p>CNS-B<br/>CNS-B was hired on December 13, 2016, under the comprehensive home care license and began providing direct care assisted living services to the licensee's resident's and supervision of the licensee's staff on August 1, 2021.</p> <p>CNS-B's employee record lacked any annual dementia care training.</p> <p>On January 29, 2025, at 3:00 p.m., CNS-B stated she had not completed any of her annual training until after the start of survey this week when she realized it was all due and she had not kept up with it.</p> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> | 01530                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                        | <p>Continued From page 62</p> <p>ULP-H's employee record lacked any annual dementia care training.</p> <p>On January 30, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated he was aware of the dementia training requirements for initial training and annual training. LALD-A stated missing the dementia care training is an issue with all of the staff. LALD-A stated some of the staff may have completed the training at one of the other facilities we own, or it has been assigned and the staff have not completed it.</p> <p>The licensee's Assisted Living Dementia Training policy dated February 21, 2022, indicated direct care staff will complete:</p> <ul style="list-style-type: none"><li>- a minimum of 8 hours of initial training on dementia care topics; and</li><li>- initial training will be completed within 160 working hours of the employment start date.</li></ul> <p>Supervisors of direct-care staff will have a minimum of 2 hours on training topics related to dementia care for each 12 months of employment after orientation.</p> <p>Direct-care employees will have a minimum of 2 hours training on topics related to dementia for each 12 months of employment.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01530                                                                                           |                                                                                                                          |  |                                                     |
| 01620<br>SS=F                                                | <p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 01620                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                        | <p>Continued From page 63</p> <p>after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for three of three residents (R2, R3, and R5).</p> <p>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).</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                 | <p>Continued From page 64</p> <p>The findings include:</p> <p>R2<br/>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision.</p> <p>On January 28, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. On January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis machine for her evening dialysis.</p> <p>R2's record included a 14-day assessment dated April 17, 2024. R2's record also included 90-days assessments dated July 17, 2024, October 18, 2024, and January 21, 2025.</p> <p>The following R2 90-day assessments were completed late:</p> <ul style="list-style-type: none"><li>- July 17, 2024, late by 15 days;</li><li>- October 18, 2024, late by 18 days; and</li><li>- January 21, 2025, late by 23 days.</li></ul> <p>R3<br/>R3 admitted to the licensee on April 6, 2023, with diagnoses that included diabetes insipidus</p> | 01620                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                        | <p>Continued From page 65</p> <p>(disorder with water regulation in the body),<br/>gastrostomy tube (G-tube) in place (a tube that is<br/>surgically inserted into the stomach through a<br/>small opening in the abdominal wall), type 2<br/>diabetes mellitus, seizure disorder, and cognitive<br/>dysfunction.</p> <p>R3's unsigned Service Plan dated January 29,<br/>2025, indicated R3 received services that<br/>included G-tube cares and free water into G-tube,<br/>bathing assistance, behavior management,<br/>medication assistance, blood glucose monitoring,<br/>Ted (compression) stocking supervision, and skin<br/>care.</p> <p>R3's record included 90-day assessments dated<br/>July 25, 2024, and October 28, 2024.</p> <p>The following R3 90-day assessments were<br/>completed late or not yet completed:<br/>- October 28, 2024, late by 5 days; and<br/>- January 21, 2025, late by 6 days and not<br/>completed.</p> <p>R5<br/>R5 admitted to the licensee on August 11, 2024,<br/>with diagnoses that included schizoaffective<br/>disorder, bipolar disorder, alcohol abuse, and<br/>major depression.</p> <p>R5's unsigned Service Plan dated January 29,<br/>2025, indicated R5 received services for<br/>medication assistance</p> <p>R5's record included a 14-day assessment dated<br/>August 22, 2024. R5's record also included a<br/>90-days assessment dated November 18, 2024.</p> <p>The following R5 90-day assessment was<br/>completed late:</p> | 01620                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                        | Continued From page 66<br><br>- November 18, 2024, late by 9 days.<br><br>On January 29, 2025, at 11:30 a.m., clinical nurse supervisor (CNS-B) stated there was not a reason the assessments were late and must have just missed them.<br><br>The licensee's Initial and On-Going Nursing Assessment of Residents policy dated February 1, 2022, indicated ongoing monitoring and review will be conducted as needed based on changes in the resident needs and will not exceed 90 calendar days from the last review date.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                       | 01620                                                                  |                                                                                                                          |  |                                                     |
| 01640<br>SS=F                                                | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                        | <p>Continued From page 67</p> <p>must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br/>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to complete a service plan within 14 days of admission for three of three residents (R2, R3, and R5).</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>On January 28, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2 and on January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis machine for her evening dialysis.</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                        | <p>Continued From page 68</p> <p>R2's medical record lacked evidence of a signed service plan prior to the date of survey entrance.</p> <p>R2's service plan, printed after the initiation of the survey, on January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision.</p> <p>R3<br/>R3 admitted to the licensee on April 6, 2023, with diagnoses that included diabetes insipidus (disorder with water regulation in the body), gastrostomy tube (G-tube) in place (a tube that is surgically inserted into the stomach through a small opening in the abdominal wall), type 2 diabetes mellitus, seizure disorder, and cognitive dysfunction.</p> <p>R3's medical record lacked evidence of a signed service plan prior to the date of survey entrance.</p> <p>R3's service plan, printed after the initiation of the survey, on January 29, 2025, indicated R3 received services that included G-tube cares and free water, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision, and skin care.</p> <p>R5<br/>R5 admitted to the licensee on August 11, 2024, with diagnoses that included schizoaffective disorder, bipolar disorder, alcohol abuse, and major depression.</p> <p>R5's medical record lacked evidence of a signed service plan prior to the date of survey entrance.</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                          |  |                                              |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>30796                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHEL HAVEN CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31274 JULLIARD ST NE<br>NORTH BRANCH, MN 55056 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01640                                                 | Continued From page 69<br><br>R5's service plan, printed after the initiation of the survey, on January 29, 2025, indicated R5 received services for medication assistance.<br><br>On January 28, 2025, at 3:35 p.m., licensed assisted living director (LALD)-A stated none of the current residents have signed service plans because they go over the services verbally with the resident's and have recently started using a new electronic charting system and have not had a chance to print them out and have the resident's or their representatives sign them.<br><br>The licensee's undated Contents of Service Plans policy indicated a finalized Service plan will be completed no later than 14 calendar days after initiation of services. Service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640                                                                                   |                                                                                                                          |  |                                              |
| 01730<br>SS=F                                         | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01730                                                                                   |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                        | <p>Continued From page 70</p> <p>(1) a statement describing the medication management services that will be provided;</p> <p>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;</p> <p>(3) documentation of specific resident instructions relating to the administration of medications;</p> <p>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;</p> <p>(5) identification of medication management tasks that may be delegated to unlicensed personnel;</p> <p>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and</p> <p>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.</p> <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop an individual medication management plan to include all required content for three of three residents (R2, R3, and R4).</p> | 01730                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                        | <p>Continued From page 71</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>On January 28, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2 and on January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis machine for her evening dialysis.</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision.</p> <p>R2's record lacked an individual medication management plan with the following content:</p> <ul style="list-style-type: none"><li>- a statement describing the medication management services that will be provided;</li><li>- identification of persons responsible for monitoring medication supplies and ensuring that</li></ul> | 01730                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                        | <p>Continued From page 72</p> <p>medication refills are ordered on a timely basis;<br/>and<br/>- identification of medication management tasks<br/>that may be delegated to unlicensed personnel<br/>that included oral medications.</p> <p><b>R3</b><br/>R3 admitted to the licensee on April 6, 2023, with<br/>diagnoses that included diabetes insipidus<br/>(disorder with water regulation in the body),<br/>gastrostomy tube (G-tube) in place (a tube that is<br/>surgically inserted into the stomach through a<br/>small opening in the abdominal wall), type 2<br/>diabetes mellitus, seizure disorder, and cognitive<br/>dysfunction.</p> <p>R3's unsigned Service Plan dated January 29,<br/>2025, indicated R3 received services that<br/>included G-tube cares and free water, bathing<br/>assistance, behavior management, medication<br/>assistance, blood glucose monitoring, Ted<br/>(compression) stocking supervision, and skin<br/>care.</p> <p>R3's record lacked an individual medication<br/>management plan with the following content:<br/>- identification of medication management tasks<br/>that may be delegated to unlicensed personnel<br/>that included oral medications.</p> <p><b>R4</b><br/>R4 admitted to the licensee on January 15, 2025,<br/>with diagnoses that included chronic obstructive<br/>pulmonary disease (COPD), chronic heart failure,<br/>major depressive disorder, obstructive sleep<br/>apnea, seizure disorder.</p> <p>R4's unsigned service plan dated January 29,<br/>2025, indicated R4 received services that<br/>included assistance with continuous positive</p> | 01730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                        | <p>Continued From page 73</p> <p>airway pressure (CPAP) machine, medication assistance, oxygen assistance, housekeeping, and oxygen saturation monitoring.</p> <p>R4's record lacked an individual medication management plan with the following content:</p> <ul style="list-style-type: none"><li>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and</li><li>- identification of medication management tasks that may be delegated to unlicensed personnel that included oral medications.</li></ul> <p>On January 29, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated she was aware of the requirements of the individualized medication management plans and is not sure why some of the required information is missing.</p> <p>The licensee's individualized Medication, Treatment &amp; Therapy Management Plan policy indicated the RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include:</p> <ul style="list-style-type: none"><li>- Statement of the medication management services provided to the resident;</li><li>- Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions;</li><li>- Documentation of specific resident instructions relating to the administration of medications;</li><li>- Identification of persons responsible for monitoring and ensuring timely refills of medications;</li><li>- Identification of medication management tasks that may be delegated to an unlicensed person;</li><li>- Procedure for notifying a registered nurse or</li></ul> | 01730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                        | Continued From page 74<br><br>appropriate licensed health professional when a problem arises with medication management services; and<br>- Resident-Specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01730                                                                                           |                                                                                                                          |  |                                                     |
| 01790<br>SS=F                                                | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for | 01790                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01790                                                        | <p>Continued From page 75</p> <p>giving medications to residents; and<br/>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br/>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br/>(ii) how the container or containers must be labeled;<br/>(iii) written information about the medications to be provided;<br/>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br/>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br/>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br/>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the</p> | 01790                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01790                                                        | <p>Continued From page 76</p> <p>licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (unlicensed personnel/housing manager (ULP/HM)-F).</p> <p>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).</p> <p>The findings include:</p> <p>ULP/HM-F was hired on August 12, 2024, to perform direct care services to the licensee's residents.</p> <p>ULP/HM-F's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available.</p> <p>On January 30, 2025, at 12:25 p.m., licensed assisted living director (LALD)-A stated the staff are able to set up medications for residents for a leave of absence. LALD-A stated they do not have any evidence of training on medications for resident's sent on leave of absence by any of the ULP's, they train them how to set the medications up in the electronic charting system but do not document this training anywhere and do not have competencies for this task.</p> <p>The licensee's Delegation of Medications to be</p> | 01790                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01790                                                        | <p>Continued From page 77</p> <p>Given to Residents by Unlicensed Staff for Residents Time Away from Home policy dated November 30, 2024, indicated our facility will provide the necessary medications, education, instructions and support to meet the resident's medication needs when they are away from home if the facility provides assistance with self-administration of medication, administration, administration or storage of medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medication.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01790                                                                                           |                                                                                                                          |  |                                                        |
| 01880<br>SS=D                                                | <p><b>144G.71 Subd. 19 Storage of medications</b></p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, record review the licensee failed to properly store and secure medications, as required for one of one resident (R2).</p> <p>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</p>                                                                                                                                                              | 01880                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                        | <p>Continued From page 78</p> <p>resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>On January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis machine for her evening dialysis. The surveyor noted two tubes of gentamicin cream located in R2's storage bin that included other dialysis supplies. ULP/HM-F stated the cream is kept there so we can apply it to R2's skin.</p> <p>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision.</p> <p>R2's individualized medication management plan dated January 21, 2025, indicated medication self-administration is not applicable for this resident. Interventions in place to prevent the diversion of medication by the resident or others who may have access to the medications: all medications locked. Secure storage of all medications: locked cabinet.</p> | 01880                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                        | Continued From page 79<br><br>On January 29, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the medication should not be stored in R2's bedroom without updating the medication management plan and she did not realize the medication was being stored in R2's bedroom.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 01880                                                                                           |                                                                                                                          |  |                                                     |
| 01940<br>SS=F                                                | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy | 01940                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                        | <p>Continued From page 80</p> <p>received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed and maintained a current individualized treatment and therapy record for two of two residents (R2 and R3) who had ordered treatments.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis (PD) machine for her evening dialysis.</p> <p>R2<br/>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                        | <p>Continued From page 81</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Thrombo-Embolus Deterrent (TED) stocking supervision.</p> <p>R2's record contained an individualized treatment and therapy plan for TED stockings which included all the required information.</p> <p>R2's record contained an individualized treatment and therapy plan for blood glucose monitoring which lacked:</p> <ul style="list-style-type: none"><li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li><li>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</li></ul> <p>R2's record lacked an individualized treatment and therapy plan for peritoneal dialysis connection and machine set up which contained the following:</p> <ul style="list-style-type: none"><li>- a statement of the type of services that will be provided;</li><li>- documentation of specific resident instructions relating to the treatments or therapy administration;</li><li>- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</li></ul> | 01940                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                        | <p>Continued From page 82</p> <p>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>R3<br/>R3 admitted to the licensee on April 6, 2023, with diagnoses that included diabetes insipidus (disorder with water regulation in the body), gastrostomy tube (G-tube) in place (a tube that is surgically inserted into the stomach through a small opening in the abdominal wall), type 2 diabetes mellitus, seizure disorder, and cognitive dysfunction.</p> <p>R3's unsigned Service Plan dated January 29, 2025, indicated R3 received services that included G-tube cares, free water into G-tube, bathing assistance, behavior management, medication assistance, blood glucose monitoring, TED stocking supervision, and skin care.</p> <p>R3's record contained an individualized treatment and therapy plan for blood glucose monitoring which lacked:<br/>- documentation of specific resident instructions relating to the treatments or therapy administration.</p> <p>R3's record contained an individualized treatment and therapy plan for skin care which lacked:</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                        | <p>Continued From page 83</p> <ul style="list-style-type: none"><li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li><li>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</li></ul> <p>R3's record lacked an individualized treatment and therapy plan for G-tube cares, free water into G-tube, and TED stocking supervision which contained the following:</p> <ul style="list-style-type: none"><li>- a statement of the type of services that will be provided;</li><li>- documentation of specific resident instructions relating to the treatments or therapy administration;</li><li>- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</li><li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li><li>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</li></ul> <p>On January 29, 2025, at 11:30 a.m., clinical nurse</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                        | <p>Continued From page 84</p> <p>supervisor (CNS)-B stated there is not a reason why there is not an individualized treatment plan for R2's peritoneal dialysis or R3' G-tube or Ted stockings. CNS-B stated she did not realize the treatment plans for R2 and R3 were missing some of the required content and thought when items were entered into the assessments the computer system automatically pulled the information required into the treatment plan.</p> <p>The licensee's Individualized Medication, Treatment &amp; Therapy Management Plans policy dated July 1, 2022, indicated RN will develop a treatment and therapy management plan for each resident receiving treatment and /or therapy management services. The treatment and therapy management plan will include:</p> <ul style="list-style-type: none"><li>- statement of the type of services provided;</li><li>- documentation of specific resident instructions relating to the treatments and/or therapy administration;</li><li>- identification of treatment or therapy task that may be delegated to an unlicensed staff member;</li><li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy to prevent possible complications or adverse reactions.</li></ul> <p>Treatment and therapy management plans will be current and updated when there are changes.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01940                                                                                           |                                                                                                                          |  |                                                        |
| 01950<br>SS=I                                                | <p>144G.72 Subd. 4 Administration of treatments and therapy</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 01950                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                        | <p>Continued From page 85</p> <p>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:</p> <p>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform treatments and the ULP demonstrated competency back to the registered nurse (RN) for three of three employees (unlicensed personnel/housing manager (ULP/HM)-F, and unlicensed personnel (ULP)-H and ULP-J).</p> <p>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</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                        | <p>Continued From page 86</p> <p>has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 29, 2025, at 8:00 a.m., unlicensed personnel/housing (ULP/HM)-F stated all the staff assist R2 with her peritoneal dialysis and blood glucose monitoring and R3 with his gastrostomy tube (G-tube) and blood glucose monitoring. ULP/HM-F stated that they received step by step instructions last week from the dialysis company because it was requested by the facility, due to the staff had an issue with the dialysis machine modem last week and could not get it to work. ULP/HM-F stated clinical nurse supervisor (CNS)-B completed the initial training on the dialysis and the G-tube care to her and she teaches new staff how to provide the treatments.</p> <p>ULP/HM-F<br/>ULP/HM-F was hired on August 12, 2024, to perform direct care services to the licensee's residents.</p> <p>R2's services delivered record for January 1, 2, 3, 4, 6, 9, 10, 11, 13, 14, 15, 18, 19, 20, 22, 24, and 27, 2025, indicated ULP/HM-F completed some or all of the following treatments for R2:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring; and</li><li>- Thrombo-Embolus Deterrent (TED) stockings.</li></ul> <p>R3's services delivered record for January 1, 3, 4, 6, 11, 13, 14, 15, 18, 19, 20, 22, 24, and 27, 2025, indicted ULP-HM-F completed some or all of the following treatments for R3:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring;</li><li>- G-tube cares; and</li><li>- free water into G-tube.</li></ul> | 01950                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                        | <p>Continued From page 87</p> <p>ULP/HM-F's employee record lacked evidence a registered nurse or authorized licensed health professional had instructed the unlicensed personnel in the proper methods for each resident and the unlicensed personnel had demonstrated ability to competently follow the procedure for the following treatments:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring;</li><li>- G-tube cares;</li><li>- free water into G-tube; and</li><li>- Thrombo-Embolus Deterrent (TED) stockings.</li></ul> <p>ULP-H<br/>ULP-H was hired on November 9, 2021, to perform direct care services to the licensee's residents.</p> <p>R2's services delivered record for January 4, 15, 16, 17, 18, 21, 22, 23, and 25, 2025, indicated ULP-H completed the following treatments for R2:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring.</li></ul> <p>R3's services delivered record for January 2, 4, 6, 15, 16, 17, 18, 21, 22, 23, and 25, 2025, indicated ULP-H completed the following treatments for R3:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring; and</li><li>- free water into G-tube.</li></ul> <p>ULP-H's employee record lacked evidence a registered nurse or authorized licensed health professional had instructed the unlicensed personnel in the proper methods for each resident and the unlicensed personnel had demonstrated ability to competently follow the procedure for the following treatments:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring; and</li><li>- free water into G-tube.</li></ul> <p>ULP-J<br/>ULP-J was hired on July 9, 2024, to perform</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                        | <p>Continued From page 88</p> <p>direct care services to the licensee's residents.</p> <p>R2's services delivered record for January 8, 20, and 27, 2025, indicated ULP-J completed the following treatments for R2:</p> <ul style="list-style-type: none"><li>- peritoneal dialysis machine set-up; and</li><li>- blood glucose monitoring.</li></ul> <p>R3's services delivered record for January 15, 20, and 27, 2025, indicated ULP-J completed the following treatments for R3:</p> <ul style="list-style-type: none"><li>- blood glucose monitoring; and</li><li>- free water into G-tube.</li></ul> <p>ULP-J's employee record lacked evidence a registered nurse or authorized licensed health professional had instructed the unlicensed personnel in the proper methods for each resident and the unlicensed personnel had demonstrated ability to competently follow the procedure for the following treatments:</p> <ul style="list-style-type: none"><li>- peritoneal dialysis machine set-up;</li><li>- blood glucose monitoring; and</li><li>- free water into G-tube.</li></ul> <p>On January 29, 2025, CNS-B stated she trains the staff but did not realize that blood glucose monitoring, peritoneal dialysis, or G-Tubes would be considered treatments, and the unlicensed staff would need competencies for these types of cares.</p> <p>On January 30, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated there is not a reason the competencies had not been completed or were missed and he agrees the evidence of completed training/competency of treatments is an issue with all the unlicensed staff.</p> | 01950                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                        | <p>Continued From page 89</p> <p>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated February 1, 2022, indicated the registered nurse (RN) may delegate unlicensed personnel the task of providing assistance with treatments and therapies if the unlicensed personnel have satisfied the training requirements and:</p> <ul style="list-style-type: none"><li>- before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer treatments and therapies and the unlicensed personnel have demonstrated the ability to competently follow the procedures;</li><li>- the RN has developed written, specific instruction for each resident;</li><li>- the RN has communicated with the unlicensed personnel about the individual needs of the resident; and</li><li>- the RN has documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures.</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 01950                                                                                           |                                                                                                                          |  |                                                        |
| 01960<br>SS=D                                                | <p><b>144G.72 Subd. 5</b> Documentation of administration of treatments</p> <p>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 01960                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01960                                                        | <p>Continued From page 90</p> <p>document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure documentation of administration of or the reason why a treatment was not administered and any follow-up procedures that were provided for one of two residents (R2) receiving treatments.</p> <p>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 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).</p> <p>The findings include:</p> <p>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior management, medication assistance, blood glucose monitoring, and Thrombo-Embolus Deterrent (TED) stockings.</p> <p>R2' record contained a physician order dated September 17, 2024, for TED stockings.</p> | 01960                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01960                                                        | <p>Continued From page 91</p> <p>R2's record included a Services Delivered Record for December 2024 and January 2025. The December 2024 record indicated R2 had not received the Ted stocking service December 1, 2024 - December 31, 2024. The January 2025 record indicated R2 had not received the Ted stocking service from January 1, 2025 - January 26, 2025.</p> <p>On January 29, 2025, at 11:30 a.m., clinical nurse supervisor stated she was not aware R2's Ted stockings had not been applied for the last two months and had not followed up with the provider to advise of this service not being completed or to get an order to put service on hold while trying to get a new pair.</p> <p>The licensee's Resident Records policy dated February 1, 2022, indicated the resident record will contain:</p> <ul style="list-style-type: none"><li>- all records of communications pertinent to the resident's assisted living services;</li><li>- documentation that services have been provided as identified in the service plan; and</li><li>- documentation of significant changes in the resident's status and actions taken in response to these changes and the resident's needs, including reporting to the appropriate supervisor or health care personnel.</li></ul> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01960                                                                                           |                                                                                                                          |  |                                                        |
| 01970<br>SS=F                                                | <p>144G.72 Subd. 6 Treatment and therapy orders</p> <p>There must be an up-to-date written or</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 01970                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01970                                                        | <p>Continued From page 92</p> <p>electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's two residents (R2 and R3) receiving treatments.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2<br/>R2 admitted to the licensee on April 3, 2024, with diagnoses that included end stage renal disease, type 2 diabetes mellitus, cardiovascular disease, major depression, attention deficit disorder with hyperactivity, and bipolar disorder.</p> <p>R2's unsigned Service Plan dated January 29, 2025, indicated R2 received services that included assist with dialysis connection and machine set up, bathing assistance, behavior</p> | 01970                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |  |                                                     |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>30796</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                        | <p>Continued From page 93</p> <p>management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision.</p> <p>On January 29, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel/housing manager (ULP/HM)-F set up R2's peritoneal dialysis machine for her evening dialysis.</p> <p>R2's record contained provider orders dated May 8, 2024, for peritoneal dialysis (PD) and a physician order dated September 17, 2024, for Thrombo-Embolus Deterrent (TED) stockings.</p> <p>R2's record did not contain current provider orders for blood glucose monitoring.</p> <p>R3<br/>R3 admitted to the licensee on April 6, 2023, with diagnoses that included diabetes insipidus (disorder with water regulation in the body), gastrostomy tube (G-tube) in place (a tube that is surgically inserted into the stomach through a small opening in the abdominal wall), type 2 diabetes mellitus, seizure disorder, and cognitive dysfunction.</p> <p>R3's unsigned Service Plan dated January 29, 2025, indicated R3 received services that included G-tube cares and free water, bathing assistance, behavior management, medication assistance, blood glucose monitoring, Ted (compression) stocking supervision, and skin care.</p> <p>R3's record contained provider orders dated, November 12, 2024, for blood glucose monitoring and a provider order dated July 15, 2024, for skin care.</p> | 01970                                                                                           |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01970                                                        | <p>Continued From page 94</p> <p>R3's record did not contain a current provider order for Ted stockings or G-Tube.</p> <p>On January 29.2025, at 3:10 p.m., licensed assisted living director (LALD)-A stated he was unable to find an order for blood glucose monitoring for R2. LALD-a stated R3 does not have a current order for the G-tube and or the Ted stockings. LALD-A stated these orders were misplaced or missing.</p> <p>The licensee's Resident Records policy dated February 1, 2022, indicated the resident record will contain:</p> <ul style="list-style-type: none"><li>- orders or prescriptions for medications, treatments or therapies that the agency will be managing.</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01970                                                                                           |                                                                                                                          |  |                                                        |
| 02310<br>SS=F                                                | <p><b>144G.91 Subd. 4 (a) Appropriate care and services</b></p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to secure oxygen tank storage for one of one resident (R4).</p>                                                                                                                                                                                                                | 02310                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02310                                                        | <p>Continued From page 95</p> <p>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).</p> <p>The findings include:</p> <p>On January 28, 2025, at 8:45 a.m., the surveyor observed three portable oxygen tanks with attached regulators (attachment that reduces the high pressure of oxygen from a tank to a safe, usable level) sitting on the floor of R4's bedroom. The oxygen tanks were not secured in a noncombustible rack.</p> <p>On January 28, 2025, at 11:00 a.m., the surveyor and clinical nurse supervisor (CNS)-B went to R4's bedroom and observed the oxygen tanks. CNS-B confirmed the tanks were unsecured and stated she would expect the oxygen tanks to be stored in a holder and did not realize the portable oxygen tanks did not have a storage rack and will call the oxygen supply company for them to deliver one.</p> <p>The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over.</p> | 02310                                                                                           |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                              |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>30796</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHEL HAVEN CARE</b> |                                                                                                                              |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>31274 JULLIARD ST NE<br/>NORTH BRANCH, MN 55056</b>                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02310                                                        | Continued From page 96<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days      | 02310                                                                     |                                                                                                                          |  |                                                        |





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

Type: Full  
Date: 01/27/25  
Time: 11:30:00  
Report: 1025251014

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Bethel Haven Care  
31274 Julliard St Ne  
North Branch, MN55056  
Isanti County, 30

**Establishment Info:**

ID #: 0039050  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6516747433  
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.

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

Discussed deliming dish machine and routine cleaning and filling for salt in softener, pest control, methods for cooling TCS foods, clearing the prep sink drain, sink designation

Outside freezer used for personal items not in use during inspection

Discussed routine testing for the well - confirmed well testing is not performed by MDH due to not meeting 25 persons for DWP designation. Perform an annual coliform and nitrate test and maintain 2 years of results available for review

CFPM copy posted, covers 2 facilities

<https://www.health.state.mn.us/communities/environment/water/wells/waterquality/index.html>

When well testing results are received, email to [casey.kipping@state.mn.us](mailto:casey.kipping@state.mn.us)



Type: Full  
Date: 01/27/25  
Time: 11:30:00  
Report: 1025251014  
Bethel Haven Care

# Food and Beverage Establishment Inspection Report

Page 2

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

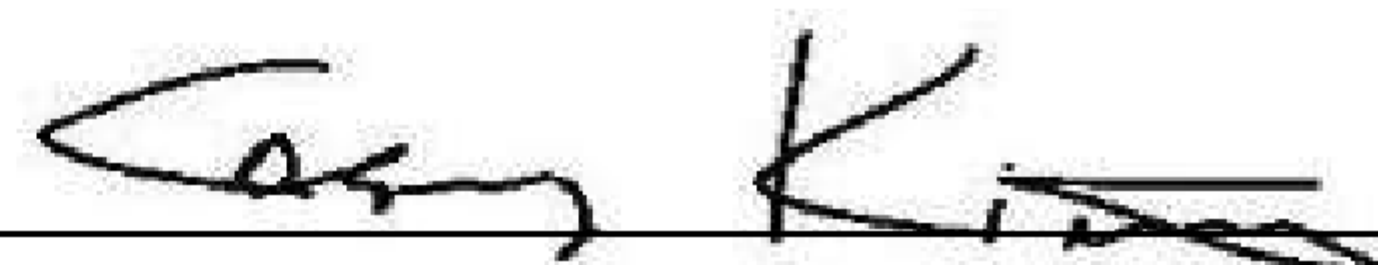
I acknowledge receipt of the Minnesota Department of Health inspection report number 1025251014 of 01/27/25.

Certified Food Protection Manager: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expires: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signed: \_\_\_\_\_

Establishment Representative

Signed:  \_\_\_\_\_

Casey Kipping  
Public Health Sanitarian III  
Freeman Building St Paul  
651-201-4513  
casey.kipping@state.mn.us