Electronically Delivered

April 13, 2023

Licensee
Bel Rae Senior Living
2330 Mounds View Boulevard
Mounds View, MN 55112

RE: Project Number(s) SL31586015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jess Schoenecker, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-215-6894 / 651-281-9796

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31586	A. BUILDING: _____ B. WING _____	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL RAE SENIOR LIVING	2330 MOUNDS VIEW BOULEVARD MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31586015 On March 20, 2023, through March 22, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 92 residents, with 61 of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated March, 20, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Unlicensed personnel (ULP)-B was hired on February 14, 2022. On March 21, 2023, at 8:46 a.m., ULP-B was observed providing cares for a resident (R1). ULP-B stood R1 up off the toilet and cleaned R1's perineal area after R1 urinated and had a bowel movement. ULP-B had two sets of gloves on	0 510		

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0 510	Continued From page 3 (double-gloved) and doffed (removed) the first pair of gloves after he provided peri-cares. ULP-B hooked his thumb under the first pair of gloves to pull them off and contaminated the second pair of gloves with his first pair of gloves. ULP-B used his second pair of gloves to pull up R1's pants and to hold her arm as he assisted her with ambulation (walking). On March 21, 2023, at 8:55 a.m., ULP-B was observed administering Polyvinyl Alcohol 1.4% lubricating eye drops into R1's eyes without performing hand hygiene or doffing his second pair of gloves after providing peri-cares. On March 21, 2023, at 8:55 a.m., ULP-B stated he had not removed his second pair of gloves or performed hand hygiene prior to eye drop administration. ULP-B stated he was taught to only wear one set of gloves at a time and he only double-gloved during toileting cares. On March 21, 2023, at 9:28 a.m., Director of Nursing (DON)-A stated double-gloving should never be done under any circumstances as it could contaminate the second pair of gloves. DON-A stated reeducation for ULP-B would be required. The licensee's Infection Control 8.07 Gloves policy dated February 11, 2022, indicated the following procedure: "1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper	0 510		

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0 510	Continued From page 4 receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle 7. Rewash hands." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 5 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained documentation of required orientations training and a registered nurse (RN) 30-day supervision of staff performing delegated tasks for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired February 14, 2022, and was observed providing direct care services to residents on March 21, 2023, at 8:46 a.m. ULP-B's employee record lacked documentation of a RN conducting direct supervision of ULP-B performing delegated tasks within 30-days of providing services. Further, ULP-B's employee record lacked the required orientation training to be completed prior to providing services to residents which included: -overview of assisted living statutes; -review of provider policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors;	0 650		

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0 650	Continued From page 6 -Assisted Living Bill of Rights; -handling resident complaints, reporting complaints and where to report; -consumer advocacy services; -review of types of assisted living services the employee would provide and scope of practice; -principles of person-centered planning/service delivery; -hearing loss training; and -orientation to specific resident and services provided. ULP-B's employee record included an Educare (online training platform) transcript which included required orientation trainings completed on August 26, 2022, and September 2, 2022, over six (6) months after ULP-B's date of hire on February 14, 2022. On March 21, 2023, at 8:55 a.m., ULP-B stated he had received orientation training, competency training and an RN did observe him performing tasks when he first started. On March 21, 2023, at 11:48 a.m., licensed assisted living director (LALD)-D stated ULP-B completed the required orientation training late after an audit of ULP-B's chart was completed. LALD-D stated during the audit it was also discovered ULP-B's employee record lacked a 30-day RN supervision. On March 21, 2023, at 11:59 a.m., director of nursing (DON)-A stated ULP-B completed the required orientation training late after an audit of ULP-B's chart was completed. DON-A stated ULP-B did not have a 30-day RN supervision in his employee record and was unsure if one had been completed at the time of hire as she was not working for the facility. DON-A stated it was	0 650		

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0 650	Continued From page 7 discovered ULP-B did not have a 30-day RN supervision during an employee record audit in August 2022, and should have been addressed then but was not. DON-A stated they would address the issue immediately. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated February 11, 2022, indicated: "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. 2. This requirement also applies to staff that have not performed delegated tasks for one (1) year or longer. 3. The supervision should be through the direct and indirect observation of the unlicensed personnel performing the services. The resident or resident's responsible person may be interviewed to assure they are satisfied with the services they are receiving. 4. It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. 5. Documentation of supervision activities will be retained in the employee's record." The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated: "3. The orientation must contain the following topics: -An overview of the appropriate Assisted Living statutes and rules -An introduction and review of the facility's policies and procedures related to the provision of	0 650		

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0 650	Continued From page 8	0 650		

assisted living services by the individual staff person

-Handling of emergencies and use of emergency services

-Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC)

-The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights

-Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person

-Handling of residents' complaints, reporting of complaints, and where to report complaints, including Information on the Office of Health Facility Complaints

-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

-A review of the types of assisted living services the employee will be providing and the facility's category of licensure

-The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed

-The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services

-The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and

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0 650	Continued From page 9 neglect, and an explanation that any act that constitutes maltreatment is prohibited. 4. In addition to the topics listed above, 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: -An explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication -Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or -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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 10 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection of smoke alarms inside the resident apartment unit 332. This has the potential to directly affect the resident in unit 332. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 20, 2023, approximately from noon to	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 3:00 p.m., survey staff toured the facility with the director of maintenance (M)-E. During the tour, the required smoke alarms located in resident one-bedroom apartment unit 332 were not interconnected. The finding was evident when the M-E tested the smoke alarms by activating each smoke alarm and each sounded local. The M-E confirmed the finding. On March 20, 2023, at approximately 4:00p.m., during the exit interview, the licensed assisted living director-D and the M-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.	0 800		

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	31586	A. BUILDING: _____ B. WING _____	03/24/2023

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0 800	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 20, 2023, approximately from noon to 3:00 p.m., survey staff toured the facility with the director of maintenance (M)-E. During the tour, survey staff observed the following: 1. The "PTAC" wall-mounted air handling units: -The filters for the "PTAC" wall-mounted units inside the resident apartment units were filled with dust (units 110, 117, 129, 123, 133, 137, 230, and laundry room filters. The M-E explained that most filters will be in similar conditions unless they were recently turnover for new tenants. The M-E also stated that their filter cleaning schedule is twice per year. -In resident apartment unit 116, there was a missing filter in the PTAC wall-mounted unit. The DM-E verbally and visually confirmed the findings and agreed that they will ensure to clean out all "PTAC" unit filters. 2. The fire-rated doors for the 2nd and 3rd-floor laundry rooms were wedged open preventing them to close during a fire to protect the corridor. 3. The kitchen door on the first floor (adjacent to the trash/recycle room) to the corridor missing hardware to be positively latched when closed from altering the door hardware. 4. Trash/recycle door on the first floor failed to positively latch when closed. Also, the trash	0 800		

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0 800	Continued From page 13 chute inside the trash/recycle room failed to operate or open and requires repair. 5. Maintenance fire-rated door in the basement (lower)-level floor wedged open. 6. Provide approved cigarette butt receptors for designated employee smoking areas. On March 20, 2023, at approximately 3:55 p.m., during the exit interview, the licensed assisted living director (LALD)-D and the M-E acknowledged the above finding. The LALD-D during the exit interview stated that they have one but may be buried under the snow. Additional information was received via email on Monday 03/20/2023 at 5:25 p.m. from the LALD-D with an attached pdf document Annual Fire Alarm System Inspection, dated 10/22/2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 14 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan, the minimum frequency of employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 15 The findings include: On March 20, 2023, at approximately 3:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the director of maintenance (M)-E and the licensed assisted living director (LALD)-D. At approximately 3:50 p.m., document review and interview with the LALD-D and the M-E indicated the following findings: 1. The evacuation floor layout lacked a location and number of sleeping rooms. During the interview with the M-E, the LALD-D verified that the fire safety and evacuation plan for the facility lacked these provisions. 2. The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. Survey staff explained to the LALD-D and the M-E that the minimum required employee training is twice a year after new hire orientation for fire safety and evacuation. The facility policy provided by the LALD-D met the training frequency requirement, however, no record of documented dates for training was provided for review to substantiate training for the year 2022 and to date in 2023. 3. The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review. 4. The drill records showed an insufficient number of employee fire evacuation drills performed to date. Drill records provided for review to date were 6/29/2022 (noted as 10:35 -1st shift), 1/31/2023, (noted as 10:22 a.m.), and 2/15/2023 (noted as 15:09). All drill records lacked evacuation information, Survey staff	0 810		

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0 810	Continued From page 16 explained to the LALD-D and the M-E that evacuation must also nr included in the fire drills and the minimum required frequency of two fire evacuation drills for employees is twice per year per shift with at least one evacuation every other month, totally six evacuation drills per year. On March 20, 2023, at approximately 4:15 p.m., during the exit interview, the LALD-D and the M-E acknowledged the above findings. The M-E stated they will perform a 3rd shift drill soon. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 17 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1, R2, R3, and R4's Assisted Living Contracts included clauses indicating the licensee was not liable to residents in the following incidents: Personal Property: Resident agrees that Provider is not responsible for any loss of or damage to a resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to resident property due to fire, water, tornado or other act of nature and events beyond Provider's control. Liability for Damage: Provider is not liable to resident for any injury, death, or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of Provider's own negligence or omissions. On March 21, 2022, at 1:40 p.m., licensed assisted living director (LALD)-D confirmed R1, R2, R3, and R4's assisted living contracts did not have an addendum completed for contracts signed prior to February 2023. LALD-D said the new contract they provided dated February 2023, is what they were using going forward. No further information was provided.	0 970		

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0 970	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01540		

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01540	Continued From page 19 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired February 14, 2022, and was observed providing direct care services to residents on March 21, 2023, at 8:46 a.m. ULP-B's employee record lacked documentation of the required 8 hours of dementia care training within 80 hours of employment start date. On March 21, 2023, at 11:48 a.m., licensed assisted living director (LALD)-D stated there was no documentation of completed dementia care training within the required time frame for ULP-B. On March 21, 2023, at 11:59 a.m., director of nursing (DON)-A stated ULP-B did not have documentation of completed dementia care training within the required time frame for ULP-B. DON-A stated it was discovered ULP-B did not have the required dementia training during an employee record audit in August 2022. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated, "Direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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01620	Continued From page 20	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a change of condition reassessment for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

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01620	Continued From page 21 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's service plan dated February 10, 2023, indicated R2 had a diagnosis of dementia and received services for EZ-Stand (mechanical lift) lift transfers, escorts, and activities of daily living (ADLs). On March 21, 2023, R2 was observed receiving her morning medications. R2's progress note dated January 26, 2023, at 4:21 p.m., written by registered nurse (RN)-F, indicated R2 had an unwitnessed fall in her apartment. R2 was assessed and RN-F found a large hematoma (a collection of pooled blood under the skin) located on the top of R2's head with significant pain when touched. R2 also reported right leg pain. 911 was called and emergency medical services transported R2 to the hospital. R2's Universal Assessment Tool dated February 8, 2023, indicated R2 was a fall risk, had a history of urinary tract infections (UTIs), bone fractures, required an assist of one with transfers with an EZ stand lift, and an assist of one for ADLs. R2's Transfer Assessment dated January 27, 2023, was completed by RN-I after R2's return from the hospital. R2's assessment was a nine-question focused assessment on R2's ability to transfer. The assessment indicated the reason for the assessment was post fall. The	01620		

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01620	Continued From page 22	01620		

assessment indicated R2 was able to follow instruction, bear weight, and transfer with an assist of one with the use of a gait belt (belt used for transfer assist).

R2's record indicated the licensee filed a Minnesota Adult Abuse Reporting Center (MAARC) report on January 27, 2023, at 12:01 p.m., completed by RN-I. The MAARC report indicated, "This report was initiated due to resident's change of condition following a fall where she sustained a hematoma on the crown of her head. Services were followed upon review. Resident was seen by staff at around 1445 and resident was sitting on her chair, circa 1515 on January 26, 2023 HHA heard the resident yelling "help." Upon entering the apartment, the resident was found on the floor. Resident stated that "I fell and hit my head on the floor right here" while pointing at where resident was sitting. Resident was complaining of being dizzy and wanted to lay down on the floor. HHA placed a pillow and assisted resident to lay down while HHA was calling for help. RN arrived at the scene and was assessed, RN found a hematoma on the top of resident's head, no bleeding or open wounds noted. Resident was complaining of pain on the hematoma site and reported right leg pain, no visual injuries noted. Family was notified regarding the incident. EMS was summoned, assessed resident and transported resident to [hospital] ER [emergency room] for further evaluation. Resident was sent back to the facility at circa 1945 after ER evaluation. CT scan impression that was completed at the ER indicates: No CT findings of acute intracranial process; Unchanged chronic intracranial findings, as described; Moderate lo large right parietal vertex scalp hematoma without underlying displaced acute calvarial fracture. Morning of

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01620	Continued From page 23 01.27.23, resident is lethargic, has refused to take her medications, meals and getting out of bed. Family and PCP was notified." R3 R3 was admitted to the licensee on August 2, 2021. R1's diagnoses included Alzheimer's disease, hypertension, and urinary tract infection. R3's service plan dated March 17, 2023, indicated R3 received assistance with toileting and peri-care, change soiled pad/brief, assist with dressing, oral care, shower, and drying off. R3's Master Assessment dated March 7, 2023, indicated R3 was independent with oral care, independent with transfer, independent with ambulation/mobility, verbal reminders for dressing, verbal cueing/standby during bathing, verbal reminders for grooming, verbal reminders for toileting and independent with toileting/continence care. R3's Resident Incident Report dated March 9, 2023, indicated " Resident was observed lying on her back near her bed. It appears she may have tripped on her bedding that was partially on the floor. Resident has an abrasion/small hematoma above her right eyebrow and side of her right eye ." R3's progress note dated March 14, 2023, at 10:15 a.m., written by RN-B, indicated, "Service schedule updated by writer per families [sic] request. Added toileting assists and Additional AM and PM cares to ensure resident has good oral care and grooming, and ensure resident sleeps in her bed at night. Additional shower day added." R3's progress note dated March 16, 2023, at 1:33	01620		

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01620	Continued From page 24 p.m., written by RN-B, indicated, "Resident had not been eating much, if anything at all for last three-five days. Resident's daughter has been staying with her every day and manages to get her favorite meals but resident still denies eating." On March 21, 2023, at 9:50 a.m., R3 was observed refusing morning medications. Unlicensed personnel (ULP)-H stated R3 refused medications the past two days and had not been eating much last two weeks, and R3 has declined. On March 20, 2023, at 10:20 a.m., during the entrance conference director of nursing (DON)-A stated after a resident falls, a post fall assessment was completed to determine if the resident needs to be sent to the ER. DON-A stated if the resident returned from the ER without a hospitalization, they would do a focused assessment. DON-A stated if the resident was hospitalized, they would complete their uniform assessment tool. On March 21, 2023, at 2:31 p.m., DON-A stated they did not complete their uniform nursing assessment tool for R2 and R3's fall. DON-A stated she did do a focused assessment which was documented in the resident's progress notes. DON-A was asked if sending R2 to the ER and filing a MAARC for injuries was reason to prompt a full change of condition (COC) assessment, DON-A stated the uniform assessment tool is very long and would not expect the uniform assessment tool to be completed. On March 21, 2023, at 3:50 p.m., RN-I stated a COC assessment was not required for R2 after returning from the hospital since there was no serious injury. RN-I stated she did complete a	01620		

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	31586	A. BUILDING: _____ B. WING _____	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL RAE SENIOR LIVING	2330 MOUNDS VIEW BOULEVARD MOUNDS VIEW, MN 55112

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01620	Continued From page 25 transfer assessment to assess R2's ability to transfer. RN-I stated the following day on January 27, 2023, R2 was observed being lethargic, refused to take her medications and meals and getting out of bed. DON-A acknowledged no post fall monitoring, such as neurological checks after a head strike, were completed. On March 21, 2023, at 3:50 p.m. DON-A acknowledged R3's Service Plan was updated after last nursing assessment and services were added but there was no documentation of an assessment on change of condition or post fall monitoring. The licensee's Nursing policy dated February 11, 2022, indicated 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 assessment. No further information provided TIME PERIOD TO CORRECT: Seven (7) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

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01890	Continued From page 26 review, the licensee failed to ensure medications included required patient identifying labels, medication administration instructions, and an opened-on date for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's signed medication orders dated August 2, 2022, indicated R1 took the following medications: -dorzolamide/timolol ophthalmic solution 2%/0.5%, instill one drop into both eyes two times daily; -polyvinyl alcohol 1.4% lubricating eye drops, instill one drop into both eyes three times per day for dry eyes; and -olopatadine solution 0.2%, instill one drop into both eyes one time daily in the morning for glaucoma. On March 21, 2023, at 8:55 a.m., unlicensed personnel (ULP)-B was observed administering medications to R1. MEDICATION LABELING On March 21, 2023, at 8:55 a.m., ULP-B was observed administering medications to R1. R1's polyvinyl alcohol 1.4% lubricating eye drops box and bottle lacked a pharmacy label. The eye drop bottle was inside the original box which had a white envelope-sticker taped to it with R1's	01890		

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01890	Continued From page 27 name and medication administration instructions, "[R1] Polyvinyl A. 1.4%, Instill 1 drop into both 3 times a day," written by hand. The eye drops box also had, "#1," written on it in blue ink. On March 21, 2023, at 9:21 a.m., the medication refrigerator was observed with registered nurse (RN)-G, located in the second room of the nursing office, which had an unlabeled medication: -polyvinyl alcohol 1.4% lubricating eye drops, sterile 0.5 fluid ounces (fl oz) bottle, expiration date December 2023, prescription label had been torn off leaving, "1 of 2" written in black marker on the box. OPENED-ON DATE On March 21, 2023, at 8:55 a.m., the following medication for R1 were observed without an opened-on date: -dorzolamide/timolol ophthalmic solution 2%/0.5% Manufacturer instructions for dorzolamide/timolol ophthalmic solution 2%/0.5% revised in July 2018, indicated to, "Write down the date you open the foil pouch in the space provided on the pouch. Throw away all unused dorzolamide hydrochloride and timolol maleate ophthalmic solution preservative free single-use containers 15 days after first opening the pouch." On March 21, 2023, at 9:28 a.m., director of nursing (DON)-A stated a medication pharmacy prescription label should never be removed from a medication. DON-A stated handwritten labels should not be used to identify who a medication is for and how it should be administered. DON-A stated R1's eye drops should have been labeled with and opened-on date.	01890		

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01890	Continued From page 28 The licensee's Specialized Medication Packaging policy dated May 2022, indicated, "Specialized medication packaging is labeled by the pharmacy in accordance with applicable federal and state laws and regulations." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to identify mitigations for the hazard vulnerability or safety risk assessment plan to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or	02040		

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02040	Continued From page 29 safety but had the potential to have harmed a client'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 clients). The findings include: On March 20, 2023, at approximately 3:00 p.m., a survey staff received the safety risk assessment plan, Hazard and Vulnerability Assessment Tool (undated), along with the dementia unit addendum documentation for review. Document review indicated the license failed to develop the site-specific mitigation plan as part of the safety risk assessment on and around the property to protect the memory care residents from harm. This finding was evident as the plan included hazards and vulnerabilities but lacked mitigation documentation to protect the memory care residents from harm. The finding was confirmed during the document interview with the director of maintenance (M)-E and the licensed assisted living director (LALD)-D at approximately 4:20 p.m. Survey staff discussed the findings and explained to the LALD-D and the M-E that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and be mitigated and documentation must include the mitigations in the plan documentation to protect the memory care residents from harm. The LALD-D further acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 30 (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and	02170		

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02170	Continued From page 31 (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for an activity plan for three of four residents (R1, R2, R3) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included, but were not limited to, Alzheimer's disease. R2's diagnoses included, but were not limited to, dementia. R4's diagnoses included, but were not limited to, urinary tract infection. R1, R2 and R4's record lacked evidence the resident had been evaluated for activities to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral	02170		

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02170	Continued From page 32 interventions. In addition, R1, R2 and R4's record lacked the development of an individualized activity plan. On March 21, 2023, at 1:30 p.m., activities director (AD)-J stated she oversaw managing activities evaluations and made sure they were completed. AD-J stated some residents don't want to fill out the Activities Evaluation form and were left incomplete. AD-J provided the Activities Evaluation form for R1 and R2 which were not filled out. AD-J stated she was unable to find any documentation of Activity Evaluation for R4. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R1) with bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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02310	Continued From page 33	02310		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1
R1's service plan dated December 20, 2022, indicated R1 had a diagnosis of Alzheimer's disease and received services for activities of daily living (ADLs), medication administration, toileting, and transfers.

R1's record included a Master Assessment dated March 15, 2023, which indicated R1 required a 4-wheeled walker for ambulation, required a one-person assist with ADLs and used bedrails for bed mobility. The assessment indicated, "L. Bed Rails (Side rail assessment required)," but lacked an assessment. R1's record also included two Universal Assessment Tools dated September 26, 2022, and December 19, 2022, which indicated Side Rail/Bed Rail bed mobility devices were in use.

R1's record included a Side Rail Use Assessment form dated June 28, 2022, which indicated bedrails were safe for R1 and promoted independence.

On March 20, 2023, at approximately 11:25 a.m., R1's bed was observed to have a Halo bed rail attached to it on the right side of the bed nearest the bathroom.

On March 20, 2023, at 12:18 p.m., the director of

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02310	Continued From page 34	02310		

nursing (DON)-A was observed assessing R1's Halo bed rail and looking for manufacturer's instructions.

On March 20, 2023, at 12:18 p.m., DON-A stated she was looking for the manufacturer of R1's Halo bed rail but could not find it. DON-A stated it was firmly in place and installed correctly. DON-A stated she did not know if they had a manual for installation of the Halo bed rail.

On March 20, 2023, at 12:25 p.m., DON-A stated bed rails were supposed to be assessed every 90 days. DON-A stated resident service plans should include instruction to check bed rails regularly to make sure they were not loose. DON-A stated nursing was checking them regularly. DON-A stated they do not do the installation of bed rails, rather the family does the installation, then they are assessed by the facility nursing staff to ensure they were installed correctly and safely. DON-A stated they do risk versus benefit documentation with the family and resident.

On March 20, 2023, at 2:00 p.m., DON-A stated the 90-day assessments do acknowledge the presence of bed rails for R1 but did not have a comprehensive assessment. DON-A stated bedrail assessments may have been done on a separate bed rail assessment form and would search R1's records for the assessments.

On March 20, 2023, at 2:06 p.m., DON-A provided documentation of bed rail assessments for R1 and stated the bed rail assessment form was completed on an annual basis, R1's annual assessment was completed on June 28th, 2022, and was due to be complete again on June 28th, 2023. DON-A stated a full assessment of the bed

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02310	Continued From page 35 rails are not documented in the 90-day assessments but did acknowledge bedrails in the 90-day assessment as having been checked. DON-A stated she understood the bed rail assessments were required every 90 days. The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated: "When [licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. Staff from [licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75"." The licensee's 6.28 Side Rails policy dated August 1, 2021, did not address bed rail assessment frequency. No further information provided. TIME PERIOD FOR CORRECTION: Two (2)	02310		

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02310	Continued From page 36 days	02310		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *03/20/23*
Time: 11:30:00
Report: 1031231069

Food and Beverage Establishment Inspection Report

Location:
Bel Rae Senior Living
2330 Mounds View Boulevard
Mounds View, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0038239
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637847633
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-101.11 ***** Priority 2 *****

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

SPATULA AND SCOOP FOUND WITH MELTED PLASTIC HANDLES. KNIFE FOUND WITH PAINT CHIPPING OFF BLADE. ***ITEMS REMOVED FROM SERVICE*** REMOVE FROM SERVICE ALL DAMAGED UTENSILS THAT ARE UNCLEANABLE OR MAY CAUSE PHYSICAL CONTAMINATION.

Comply By: 03/21/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

SANITIZER TEST STRIPS EXPIRED. REPLACE TEST STRIPS WITH NEW.

Comply By: 03/23/23

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER AND MIXER GUARD FOUND WITH FOOD BUILDUP. CLEAN AND MAINTAIN CLEAN ALL FOOD CONTACT SURFACES.

Comply By: 03/23/23

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

CAULKING AROUND HANDSINK IN EXPO AREA DAMAGED/NOT CONNECTED TO HANDSINK. REMOVE OLD CAULKING AROUND HANDSINK AND REPLACE WITH NEW 100% SILICONE.

Comply By: 04/20/23

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: = 400 at Degrees Fahrenheit
Location: Sanitizer Bucket (serving area)
Violation Issued: No

Dimethyl Ethyl Benzyl Ammo: = 400 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Ambient Air Temp: = at 34 Degrees Fahrenheit
Location: Delfield Cooler (expo area)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/Sausage
Temperature: 182 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cold Hold/Egg Salad
Temperature: 36 Degrees Fahrenheit - Location: Prep Table (top)
Violation Issued: No

Process/Item: Cold Hold/Cheese
Temperature: 38 Degrees Fahrenheit - Location: Prep Table (bottom)
Violation Issued: No

Process/Item: Cooking/Sausage
Temperature: 204 Degrees Fahrenheit - Location: Stove
Violation Issued: No

Process/Item: Reheating/Soup
Temperature: 206 Degrees Fahrenheit - Location: Convection Oven
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 41 Degrees Fahrenheit - Location: Counter on Ice (serve area)
Violation Issued: No

Type: Full
Date: *03/20/23*
Time: 11:30:00
Report: 1031231069
Bel Rae Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Hot Hold/Clam Chowder
Temperature: 159 Degrees Fahrenheit - Location: Soup Well (expo area)
Violation Issued: No

Process/Item: Cold Hold/Lettuce
Temperature: 41 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Deli Ham
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

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

Inspection conducted by Chris F (MDH).

All violations discussed with Cory after inspection.

Discussed:
- Illness and illness log
- Facilities upkeep and maintenance
- Handwashing and glove use
- Sanitizer strips and concentration

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

***ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the Environmental Health inspection report number 1031231069 of 03/20/23.

Certified Food Protection Manager Cory R Franzmeier

Certification Number: FM55061 Expires: 02/08/26

Inspection report reviewed with person in charge and emailed.

Signed:_____
Cory Franzmeier
Person in Charge

Signed:_____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231069

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	2	Date	03/20/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Bel Rae Senior Living	2330 Mounds View Boulevard	Mounds View, MN	55112	7637847633

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038239		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/20/23

Inspector (Signature)