Electronically Delivered

February 19, 2025

Licensee
Beehive Homes Of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN 55311

RE: Project Number(s) SL35125016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 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.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35125016-0 On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 39 resident(s); all of whom were receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 680	Continued From page 3	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: -documentation of the date of review and any updates made to the plan based on the review; -documentation of a risk assessment that considers hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; -develop policies/procedures (P/P) to shelter in place for residents, staff, and volunteers who remain in the facility; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -develop a written communication plan that includes the following; -primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care;	0 680		

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0 680	Continued From page 5 -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); -means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and -method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives -conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On January 6, 2025, at 11:25 a.m., business office manager (BOM)-A stated, ""In full disclosure I just updated the emergency evacuation report, so that is dated today, I know you will notice that, so I wanted to point it out myself, the last one was done in March 2023."	0 680		

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0 680	Continued From page 6 On January 7, 2025, at 1:22 p.m., BOM-A acknowledged the above mentioned missing items and stated, "I wasn't flagged on some of those things in the last survey, so I just proceeded forward with what I had and did not realize I needed to have the items that are missing." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R5) personal health and medical information was kept private. 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	0 700		

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0 700	Continued From page 7 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, at 7:20 a.m., surveyor observed unlicensed personnel (ULP)-B provide morning medications to R5. ULP-B opened up RTasks (an electronic charting system used for accessing resident records for medications and treatments) on the computer screen and verified R5's medications. The screen displayed all of the resident's identifying information and medications. ULP-B then went to another area in the facility to pass medications to R5, and did not return to the unlocked computer until 7:30 a.m. The surveyor observed five other staff and six resident present in the commons area by the unattended computer. On January 7, 2025, at 7:32 a.m., surveyor observed ULP-B provide morning medications to R7. ULP-B pulled up R7's medications on Rtasks and verified R7's medications. The screen displayed all of the resident's identifying information and medications. ULP-B then went to another area in the facility to pass medications to R7, and did not return to the unlocked computer until 7:37 a.m. The surveyor observed three other staff and six resident present in the commons area by the unattended computer. On January 7, 2025, at 7:38 a.m., surveyor observed ULP-B provide morning medications to R3. ULP-B pulled up R3's medications on Rtasks and verified R3's medications. The screen displayed all of the resident's identifying information and medications. ULP-B then went to another area in the facility to pass medications to R3, and did not return to the unlocked computer	0 700		

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0 700	Continued From page 8 until 7:47 a.m. The surveyor observed three other staff and six resident present in the commons area by the unattended computer. On January 7, 2025, at 7:49 a.m., surveyor observed ULP-B provide morning medications to R6. ULP-B pulled up R6's medications on Rtasks and verified R6's medications. The screen displayed all of the resident's identifying information and medications. ULP-B then went to another area in the facility to pass medications to R6, and did not return to the unlocked computer until 8:03 a.m. The surveyor observed three other staff and six resident present in the commons area by the unattended computer. On January 7, 2025, at 8:08 a.m., ULP-B stated, "I am supposed to close it when I leave it, I thought I was closing it." On January 7, 2025, at 11:35 a.m., director of nursing (DON)-D stated, "With training we discuss [Health Information and Accountability Act] in detail and we discuss it during annual training. We discuss it such as keeping the computer private. They should be closing the laptop or closing the browser." The licensees 2.36 Resident Record - Confidentiality policy, dated August 1, 2021, indicated, "Resident records will be kept confidential and locked in a secure area where only authorized staff of [Licensee] have access to." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 800	Continued From page 9	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, at approximately 11:00 a.m., survey staff toured the facility with business office manager (BOM)-A. The following was observed.	0 800		

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0 800	Continued From page 10 GENERAL MAINTENANCE: Water closets throughout the facility, within the resident rooms, where not sealed to the floor covering. The surveyor explained to BOM-A the potential for water damage and potential unsanitary conditions. Cracking was prevalent throughout the facility on the walls and ceilings. BOM-A explained they are in the process of determining what is causing the cracking. On January 7, 2025, BOM-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 11 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, business office manager (BOM)-A provided documents on the fire safety	0 810		

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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
0 810	Continued From page 12 and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. On January 7, 2025, at approximately 11:00 a.m., BOM-A stated they understood the area of the policy that was incomplete and would work on bringing the FSEP into compliance. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were not conducted for the overnight shift staff. No other documentation was provided. On January 7, 2025, BOM-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	01/08/2025

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01760	Continued From page 13	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of three residents (R6). 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: R6 was admitted and began receiving assisted living services on August 9, 2024.	01760		

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	35125	A. BUILDING: _____ B. WING _____	01/08/2025

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01760	Continued From page 14 R6's electronic medication administration record (EMAR) dated January 1, 2024, through January 31, 2024, included Aquaphor 41% healing ointment, apply topically to legs and feet twice daily. On January 7, 2025, at 7:49 a.m. surveyor observed ULP-B dose up medications for R6. ULP-B opened up the medication cart and looked for the Aquaphor ointment, ULP-B grabbed the triamcinolone acetonide 0.1% ointment and read the label and then put the container back in the medication cart. ULP-B then looked at the computer screen reading the Aquaphor directions and opened back up the medication cart drawer and pulled out the triamcinolone acetonide 0.1% ointment to use for the Aquaphor ointment. ULP-B locked the medication cart and gathered the medications and the triamcinolone acetonide 0.1% ointment and started to leave to go administer medications to R6. The surveyor stopped the med pass and identified that triamcinolone acetonide 0.1% ointment was not the Aquaphor ointment that was ordered. ULP-B was able to identify and grab the correct item for administration. ULP-B stated, "I must have read that wrong, I thought I grabbed the right one." On January 7, 2025, at 11:37 a.m., director of nursing (DON)-D stated, "The staff are trained to do three checks against the computer, and they are supposed to be doing the six rights of medication administration." The licensee's 7.15 Medication & Treatment - Administration & Delegation policy, dated August 1, 2021, indicated, "A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	01/08/2025

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01760	Continued From page 15 resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for two of five residents (R5 and R8).	01880		

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	35125	A. BUILDING: _____ B. WING _____	01/08/2025

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01880	Continued From page 16 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: R5 was admitted and began receiving assisted living services on March 26, 2024. R5's Service Plan dated March 24, 2024, indicated R5's services included bathing assistance, mobility assistance, deep room cleaning, AM and PM dressing, grooming, laundry, linen change, meal assistance, monthly vitals, toileting, and transfer assistance. On January 7, 2025, at 7:20 a.m., surveyor observed ULP-B enter R5's room to administer medications. Located in R5's bathroom was a prescribed container of ketoconazole shampoo with an unknown amount located inside the container, and two open tubes of nystatin cream with an unknown amount located inside each tube. R8 was admitted and began receiving assisted living services on June 29, 2023. R8's Service Plan dated September 10, 2024, indicated R8's services included bathing assistance, mobility assistance, deep room cleaning, AM and PM dressing, grooming, laundry, linen change, meal assistance, medication administration, monthly vitals,	01880		

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	35125	A. BUILDING: _____ B. WING _____	01/08/2025

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01880	Continued From page 17 toileting, and transfer assistance. R8's Med Admin Summary dated January 1 through January 31, 2025, indicated R8 received medication administration. On January 7, 2025, at 7:20 a.m., surveyor observed ULP-B enter R8's room to administer medications. Located in R8's bedroom a prescribed container of Nystatin with an unknown amount located inside the container. On January 7, 2025, at 11:37 a.m., director of nursing (DON)-D stated, "Typically, we administer all medications and med passers have been instructed to bring all meds back to the med cart." The licensee's 7.11 Medication Storage policy, dated August 1, 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-E followed appropriate medication administration procedures. 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: ULP-E was hired on May 6, 2024, to provide direct care services to residents. ULP-E's employee record included a competency sign off form on all routes of medication administration. On January 7, 2025, at 8:13 a.m., ULP-E was observed to assist R6 with AM cares. ULP-B arrived in R6's room to administer medications and handed R6 a tube of bacitracin ointment and stated, "Can you please put this on him?" ULP-B left the room and ULP-E assisted R6 to the bathroom. ULP-E washed hands, donned gloves, and placed a small amount of bacitracin ointment to R6's elbow. ULP-E did not verify the ointment prior to administering it. On January 7, 2025, at 8:20 a.m., ULP-E stated, "I am a TMA (trained medication aide), so I pass	02320		

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02320	Continued From page 19 meds, and I know their meds, this is how we do creams and powders in the morning, but I should be verifying them before giving. I should be doing the six rights and three checks like I was trained." On January 7, 2025, at 11:37 a.m., director of nursing (DON)-D stated, "The staff are trained to do three checks against the computer, and they are supposed to be doing the six rights of medication administration." The licensee's 7.15 Medication & Treatment - Administration & Delegation policy, dated August 1, 2021, indicated, "A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *01/06/25*
Time: 12:00:00
Report: 1051251005

Food and Beverage Establishment Inspection Report

Location:

Beehive Homes Of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN55311
Hennepin County, 27

Establishment Info:

ID #: 0039230
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634153900
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.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE AN EMPLOYEE HANDWASH SIGN FOR THE RESTROOM AT THE FAR RIGHT END.
Comply By: 01/07/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3-COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-DAIRY COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: CUT LETTUCE-PRODUCE COOLER
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 12:00:00
Report: 1051251005
Beehive Homes Of Maple Grove

Food and Beverage Establishment Inspection Report

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

MET WITH NURSE EVALUATOR, TESA BROWN.

DISCUSSED THE FOLLOWING WITH JOSEPH AND THE CULINARY DIRECTOR, ARA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE

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 1051251005 of 01/06/25.

Certified Food Protection Manager: Joseph D. Childs

Certification Number: FM125257 Expires: 09/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Joseph D. Childs

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us