Electronically Delivered

February 20, 2025

Licensee
Beka Home Inc.
9101 Nevada Court
Brooklyn Park, MN 55445

RE: Project Number(s) SL36945016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 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 . . ."

IMPOSITION OF FINES

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0330 - 144g.30 Subd. 4 - Information Provided By Facility - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

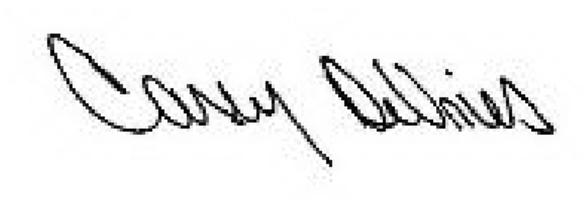
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36945	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEKA HOME INC	9101 NEVADA COURT BROOKLYN PARK, MN 55445

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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: SL36945016-0 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (the Department) with accurate and truthful information during a survey. 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 January 13, 2025, between 10:46 a.m., and 12:00 p.m., the surveyor reviewed ULP-A and ULP-B's employee records. The surveyor observed the following: - no competency evaluations related to medication administration in ULP-A or ULP-B's employee records; and - a blank form titled Competency Evaluation dated February 10, 2024, for ULP-B.	0 330		

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0 330	Continued From page 2 On January 13, 2025, at 12:08 p.m., the surveyor requested the information listed above for ULP-A and ULP-B's employee records. On January 13, 2025, at 2:00 p.m., the surveyor requested the information listed above for ULP-A and ULP-B's employee records. On January 14, 2025, at 6:49 a.m., the surveyor requested the information listed above for ULP-A and ULP-B's employee records. On January 14, 2025, at 7:44 a.m., the surveyor requested the information listed above for ULP-A and ULP-B's employee records. On January 14, 2025, at 10:08 a.m., agent/housing manager (A/HM)-C provided the surveyor with a time away from home medication competency evaluation. The surveyor requested the licensee's medication competencies not related to time away from the facility. In addition, the surveyor re-requested the initial competencies related to activities of daily living, vital signs, and mobility. The surveyor showed A/HM-C what the document looked like in another employee record. The surveyor than observed A/HM-C sit down at the computer and print the document that was just shown to them. On January 14, 2025, at 10:50 a.m., A/HM-C stood up with the papers from the printer and the employee records. The surveyor inquired if they were able to locate the document. A/HM-C stated yes and then proceeded to walk away from the surveyor and went to the upper level of the facility with the paperwork. On January 14, 2025, at 11:02 a.m., medication competencies and initial competencies were	0 330		

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0 330	Continued From page 3 received by A/HM-C. All competencies and evaluation were signed as being evaluated by A/HM-C and not a registered nurse (RN). On January 14, 2025, at 11:26 p.m., the surveyor requested A/HM-C medication competency evaluation. The surveyor observed A/HM-C print a document from the computer than place a phone call. On January 14, 2025, at 11:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated A/HM-D did not complete the competency evaluations. LALD/CNS-C stated competency evaluations should be kept in the employee record. A/HM-C stated, "sometimes I think you forgot" to sign the competency evaluations. In addition, A/HM-C stated, "mine (medication competency evaluation) is not even signed so I sent to you, and I want you to return it." On January 14, 2025, at 12:39 p.m., ULP-A stated on January 14, 2025, during the survey, they signed training and competency documents with A/HM-C. On January 15, 2025, at 11:05 a.m., A/HM-C stated the training and competency documents for ULP-A were signed on January 14, 2025, and the trainings and competency evaluations were conducted by LALD/CNS-C, however, LALD/CNS-C forgot to sign the paperwork. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		

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0 470	Continued From page 4	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 5 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: The licensee's Staffing Plan dated January 1, 2025, to January 31, 2025, included the licensee's license number, phone number, address, persons in charge, and five employee names with the scheduled hours they would work Monday through Sunday. The staffing plan lacked evidence of an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On January 14, 2025, at 11:29 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they reviewed the licensee's staffing plan every two to three months and reviewed the staffing schedule weekly. LALD/CNS-C stated they would send the surveyor documented reviews of the staffing plan. Although requested, the surveyor did not receive documentation that the staffing plan was reviewed twice per year by the CNS. The licensee's undated 4.06 Staffing & Scheduling policy read, "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week.	0 470		

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0 470	Continued From page 6 1. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and Staff experience, training, and competency." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 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;	0 480		

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0 480	Continued From page 7 (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 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:	0 480		

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0 480	Continued From page 8 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 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		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must	0 485		

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0 485	Continued From page 9 encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, at 8:10 a.m., via email, agent/housing manager (A/HM)-D provided a blank contract titled Assisted Living Contract. A/HM-D stated the blank contract was used for all residents who resided in the assisted living. The licensee's contract page included a section titled Primary Services and read, "Subject to the Resident's needs, [the licensee], will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by	0 485		

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0 485	Continued From page 10 [the licensee's] staff at the following times: Breakfast - 8:00 AM Lunch - after 12:00 PM Dinner - after 6:00 PM Health snacks are provided 2 times a day." The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. On January 14, 2025, at 11:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware the licensee could not charge residents for meals as part of their base fee package. LALD/CNS-C stated they did not know the language used in their contract would be an issue as all of the resident currently residing in the facility did not pay for meals due to being on waivered services. LALD/CNS-C stated they would revise the language in the contract related to meals being included as part of the base fee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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BEKA HOME INC	9101 NEVADA COURT BROOKLYN PARK, MN 55445

(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
0 650	Continued From page 11 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 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 the required content for two of three employees (unlicensed personnel (ULP)-A, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on September 13, 2021, to provide direct care services to residents. ULP-A's record included a performance	0 650		

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0 650	Continued From page 12 evaluation completed August 2, 2023, and lacked further performance evaluations. ULP-B ULP-B was hired on February 8, 2024, to provide direct care services to residents. ULP-A and ULP-B's employee record included an Initial Competency Checklist dated December 15, 2024, and February 10, 2024, respectively, included the following competency evaluations: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance and how to perform them; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. The competency evaluations for ULP-A and ULP-B were signed as being completed by A/HM-C. The competency evaluations lacked a signature by a registered nurse (RN) signifying the competency evaluations were completed by a RN. ULP-A and ULP-B's employee records included Competencies 2.21 Eye Drops and Ointment, and 2.29 Oral Medications dated September 10, 2024, and December 15, 2024, respectively. The competency evaluations for ULP-A and ULP-B were signed as being completed by A/HM-C. The competency evaluations lacked a signature by a RN signifying the competency evaluations were completed by a RN. On January 14, 2024, at 11:34 a.m., licensed	0 650		

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0 650	Continued From page 13 assisted living director/clinical nurse supervisor (LALD/CNS)-C stated performance evaluations were completed in August for every employee and documented on paper format. On January 14, 2025, at 11:54 a.m., LALD/CNS-C stated they trained and completed competency evaluations on activities of daily living and medication administration with the ULPs in person. LALD/CNS-C stated they sign off for the competency evaluations however, agent/housing manager (A/HM)-D also signed off on them as well because they are a "manager". LALD/CNS-C stated A/HM-D does not complete the competency evaluations. LALD/CNS-C stated competency evaluations should be kept in the employee record. A/HM-C stated, "sometimes I think you forgot" to sign the competency evaluations. On January 14, 2025, at 12:35 p.m., ULP-A stated they were trained and completed a competency evaluation with LALD/CNS-C on the topics listed above. ULP-A stated on January 14, 2025, during the survey, the training and competency documents were signed by them and A/HM-C for the topics listed above. On January 14, 2025, at 12:49 p.m., the surveyor attempted to contact ULP-B. The surveyor did not receive a return call prior to the completion of the survey. On January 14, 2025, at 1:02 p.m., A/HM-C stated ULP-B was currently unavailable for an interview as they left for a funeral out of town. On January 15, 2025, at 11:05 a.m., A/HM-C stated the training and competency documents for ULP-A were signed on January 14, 2025, and	0 650		

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0 650	Continued From page 14 the trainings and competency evaluations were conducted by LALD/CNS-C at an earlier date, however, LALD/CNS-C forgot to sign the paperwork. The licensee's undated 5.02 Competency Training Evaluations policy indicated a registered nurse (RN) would determine what nursing services may be delegated to properly trained and competency tested ULP. Training and competency evaluation would be conducted by a RN or another instructor may provide the training in conjunction with a RN. "In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required". The licensee's undated 4.05 Employee Records policy indicted the employee record would include records of all training and in-service education required and documentation of annual performance review that identified areas of improvement needed and training needs. No further information was provided.	0 650		

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0 650	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the	0 680		

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0 680	Continued From page 16 potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan located in a binder, lacked evidence of the following required content: - annual review; - emergency plan (EP) considered interruptions in communications, essential resources, medical supplies, and emerging infectious diseases; - strategies for addressing facility and community based risks; - missing resident plan; - review of the missing resident plan quarterly; - EP program patient population; - process for EP collaboration; - development of EP policies and procedures (P/P); - subsistence needs for staff and residents; - procedure for tracking of staff and residents; - P/P for evacuation; - P/P for sheltering; - P/P for medical documents; - P/P for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - name and contact information to include physicians;	0 680		

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0 680	Continued From page 17 - emergency officials contact information; - primary/alternative means for communication; - methos for sharing information; - sharing information on occupancy needs; - long term care family notifications; and - emergency prep testing requirements. On January 14, 2024, at 11:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware of the requirements of Appendix Z. LALD/CNS-C stated after the previous survey they added more contact information numbers to the emergency plan. LALD/CNS-C stated they worked with a consultant to change the licensee's EPP however, they forgot to print the new EPP and leave it at the facility. LALD/CNS-C stated they would provide the surveyor with the new EPP. LALD/CNS-C stated they reviewed the missing resident plan every six months. Although the new EPP, not kept at the facility, was requested, the surveyor only received 11 emergency policies from the licensee. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated the licensee had in place an effective and compliant EPP and the plan would be aligned with the Centers for Medicare and Medicaid Services operation manual Appendix Z. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 18 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used 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 interconnected smoke alarms. These deficient conditions had the ability to affect all staff and residents. 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	0 780		

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0 780	Continued From page 19 a large portion or all of the residents). The findings include: On January 13, 2025, at 1:00 p.m., the surveyor toured the facility with Agent/housing manager (A/HM)-D. During the tour, the surveyor observed the smoke detectors were not interconnected throughout the facility as required by MN Rules chapter 7511. During the facility tour interview on January 13, 2025, A/HM-D acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790		

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0 790	Continued From page 20 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 January 13, 2025, at 1:00 p.m., survey staff toured the facility with Agent/housing manager (A/HM)-D. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. During the facility tour interview on January 13, 2025, A/HM-D acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 21 by: Based on observation and interview, the licensee failed to maintain the physical environment 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 13, 2025, at 1:00 p.m., the surveyor toured with Agent/housing manager (A/HM)-D and the following was observed. GENERAL MAINTENANCE: 1. The upper-level bathroom ceiling had peeling paint present allowing for the potential for moisture to be obsorbed into the wall covering resulting in potential growth of mold or mildew. 2. The upper-level bathroom sink had caulking that was peeling, missing and was not properly sealed to the vanity top allowing the potential of water damage. 3. The upper-level bathroom shower had caulking that was peeling, missing and was not properly sealed to the shower wall tile allowing the potential of water damage. 4. The light in the under-stair storage area did not	0 800		

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0 800	Continued From page 22 working. On January 13, 2025, A/HM-D 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 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	0 810		

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0 810	Continued From page 23 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, at approximately 1:30 p.m., A/HM-D failed to provide documents on the fire safety and evacuation plan (FSEP). On January 13, 2025, A/HM-D stated they understood the requirements to develop and maintain a FSEP and would work to bringing the facility into compliance. On January 13, 2025, at approximately 1:30 p.m. A/HM-D provided documents on the evacuation drills for the facility. TRAINING:	0 810		

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0 810	Continued From page 24 On January 13, 2025, at approximately 1:30 p.m., A/HM-D failed to provide documents fire safety and evacuation training for staff and residents. On January 13, 2025, A/HM-D stated there was no training documentaton to provide. DRILLS: The licensee failed to conduct evacuation drills for overnight shift 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 conducted for the A.M. and P.M. shifts but no drills where conducted for the overnight shift. No other documentation was provided. On January 13, 2025, A/HM-D stated there were no drills conducted for the overnight shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	0 910		

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0 910	Continued From page 25 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents who resided in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 14, 2025, at 8:10 a.m., via email, agent/housing manager (A/HM)-D provided a blank contract titled Assisted Living Contract. A/HM-D stated the blank contract was used for all residents who resided in the assisted living. The licensee's Assisted Living Contract lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. On January 14, 2025, at 11:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware the HFID# needed to be included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36945	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEKA HOME INC	9101 NEVADA COURT BROOKLYN PARK, MN 55445

(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
0 970 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 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 living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, at 8:10 a.m., via email, agent/housing manager (A/HM)-D provided a blank contract titled Assisted Living Contract. A/HM-D stated the blank contract was used for all residents who resided in the assisted living. The licensee's Assisted Living Contract included a section titled Indemnification and read, "[the	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 970	Continued From page 27 licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee]. [sic] harmless from any claims or damages unless caused solely by negligence of [the licensee]." On January 14, 2025, at 11:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware the contract could not include language waving liability of the licensee. LALD/CNS-C stated after the previous survey they removed a section containing this language after a consultant reviewed the contract. LALD/CNS-C stated they did not know there was still language waving liability of the licensee within the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 28 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 interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three direct care employees (unlicensed personnel (ULP)-A, 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 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: ULP-A ULP-A was hired on September 13, 2021, to provide direct care services to residents.	01530		

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01530	Continued From page 29 ULP-A's employee record included six hours of dementia care training completed on September 3, 2024, and lacked further dementia care training. ULP-B ULP-B was hired on February 8, 2024, to provide direct care services to residents. ULP-B's employee record included two and a half hours of dementia care training completed on March 19, 2024, and lacked further dementia care training. On January 14, 2025, at 11:46 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated dementia care training was completed at an in person training the second week of orientation. LALD/CNS-C stated the licensee provided eight hours of initial dementia care training and 4 hours of annual dementia care training. LALD/CNS-C stated they documented the trainings by the ULP completing quizzes after ULP received the training. LALD/CNS-C stated they would email the surveyor documented dementia care training for ULP-A and ULP-B. Although requested, the surveyor did not receive further dementia care training for ULP-A or ULP-B prior to the completion of survey. On January 15, 2024, at 11:13 a.m., LALD/CNS-C stated during the previous survey they were missing dementia training hours for employee records. LALD/CNS-C stated they were completing four hours yearly to make up for the eight hours. LALD/CNS-C then stated they heard if employee was hired prior to the previous survey and did not receive the eight hours they would just need to complete two hours of dementia training yearly to meet the regulation.	01530		

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01530	Continued From page 30 The licensee's undated 5.03 Dementia training policy indicated direct care employees would complete eight hours of initial dementia training withing 160 hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an accurate face-to-face medication management reassessment for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01710		

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01710	Continued From page 31 The findings include: R1 admitted to the licensee on August 17, 2022, and began receiving assisted living services. R1's diagnoses included paranoid schizophrenia (a subtype of schizophrenia characterized by delusions of paranoia), autism, anxiety disorder, and agitation. R1's service plan signed August 17, 2022, indicated R1 received assistance with medication management, encouragement to eat, and reminders to bathe. R1's Medication Assessment and Management Plan dated August 17, 2022, indicated R1 received medication management services and needed staff assistance for medication administration. R1's Uniform Assessment Tool Sample Form dated January 22, 2023, included a medication assessment that indicated R1 received lorazepam 0.5 milligrams (mg) twice per day and dextromethorphan 10/100 mg per 10 milliliters four times per day as needed for cough. The last page of the assessment contained reviewed dates of January 17, 2024, April 16, 2024, July 15, 2024, October 12, 2024, and January 10, 2025, which indicated the assessment was reviewed and there were no changes. R1's medication administration record (MAR) dated January 1, 2025, through January 31, 2025, did not include the medication dextromethorphan and included lorazepam 1 mg two times a day and an additional tablet as needed during day when going out.	01710		

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01710	Continued From page 32 On January 14, 2025, at 11:51 a.m., licensed assisted living director/clinical nurse supervisor stated a medication assessment was completed if there was a change in the resident's condition or change in resident's medications and was not conducted annually. LALD/CNS-C stated annually the licensee would receive new orders from the provider for the resident's medication management plan. The licensee's undated 7.01 Medication Management - Assessment, Monitoring & Reassessment policy indicated the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptom or other issues that may be medication related and at minimum annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on August 17, 2022, and began receiving assisted living services. R1's service plan signed August 17, 2022, indicated R1 received assistance with medication management, encouragement to eat, and reminders to bathe. R1's medication administration record (MAR) dated January 1, 2025, through January 31, 2025, included acetaminophen 325 milligrams (mg) take one to two tablets by mouth every four hours as needed for mild pain. The MAR lacked specific instructions for when a ULP should administer one tablet of acetaminophen verses two. On January 14, 2025, at 11:59 a.m., licensed assisted living director/clinical nurse supervisor	01750		

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01750	Continued From page 34 (LALD/CNS)-C stated they received their parameters on medications from the prescriber. LALD/CNS-C stated ULPs were trained to give one tablet of acetaminophen for pain rating one through four and to give two tablets with a pain rating five through ten. LALD/CNS-C stated they did not write the instructions for acetaminophen anywhere for the ULPs to reference. LALD/CNS-C stated R1 used acetaminophen one time for knee pain. The licensee's undated 7.03 Medication Management Individualized Plan indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain documentation of specific resident instructions relating to the administration of medications. The licensee's undated 7.15 Medication & Treatment - Administration & Delegation policy indicated a registered nurse (RN) must specify, in writing, specific instructions for each resident and document those instructions in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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	01890		

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01890	Continued From page 35 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 review the licensee failed to discard expired medication for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 January 13, 2025, at 10:22 a.m., the surveyor observed the licensee's file medication file cabinet and observed the following expired medications: - R2's lorazepam 0.5 milligrams with an expiration date of December 22, 2024. On January 14, 2025, at 11:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the medication file cabinet was reviewed every couple of weeks when they received new medication from the pharmacy. LALD/CNS-C stated R2's medication was supposed to be sent out for disposal, and it was a as needed medication. The licensee's undated 7.23 Medication Disposal policy indicated the licensee shall dispose of any medications remaining with the facility that were	01890		

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01890	Continued From page 36 expired according to state and federal regulations for disposition of medication and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/13/25*
Time: 14:33:00
Report: 1036251008

Food and Beverage Establishment Inspection Report

Location:
Beka Home Inc
9101 Nevada Court
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0037811
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638988319
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.

2-200 Employee Health

2-201.11A ***** Priority 1 *****

MN Rule 4626.0040A The licensee must ensure that employees and conditional employees report to the person in charge information about their health as it relates to illnesses transmissible through food. A food employee or conditional employee must report to the person in charge the date of onset of symptoms such as vomiting, diarrhea, jaundice, sore throat with fever, boils or infected wounds, diagnosed illnesses such as norovirus, hepatitis A virus, Salmonella spp, Shigella spp, Shiga toxin-producing Escherichia coli or other enteric bacterial, viral, or parasitic pathogens, and if they have been exposed to, or are the suspected source of, a probable or confirmed disease outbreak within the last 30 days.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG SENT TO ESTABLISHMENT ALONG WITH REPORT.

Comply By: 01/14/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS BEING STORED OVER RTE FOODS IN THE FRIDGE. ISSUE CORRECTED ON SITE.

Comply By: 01/13/25

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE AS DESCRIBED ABOVE FOR MEASURING THE UST IN THE DISH MACHINE. MDH LEFT A FEW 3-TEMP THERMOLABEL STICKERS WITH ESTABLISHMENT UNTIL MORE CAN BE OBTAINED.

Comply By: 01/27/25

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.

NO CHLORINE TEST STRIPS ON SITE FOR MEASURING SANITIZER CONCENTRATION. MDH LEFT A FEW TEST STRIPS BEHIND UNTIL MORE CAN BE OBTAINED.

Comply By: 01/27/25

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME WOODEN SPOONS IN DRAWER THAT WERE IN POOR CONDITION. ITEMS WERE DISCARDED ON SITE.

Comply By: 01/13/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED LEFTOVER RICE AND PASTA IN THE FRIDGE. ITEMS DISCARDED ON SITE.

Comply By: 01/13/25

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: SAMSUNG FRIDGE
Violation Issued: No

Type: Full
Date: *01/13/25*
Time: 14:33:00
Report: 1036251008
Beka Home Inc

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: SANSUNG FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ASHLEY CREWS. INSPECTION CONDUCTED IN PRESENCE OF NAS NURE, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

*FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT 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.

Type: Full
Date: *01/13/25*
Time: 14:33:00
Report: 1036251008
Beka Home Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036251008 of 01/13/25.

Certified Food Protection Manager: HUSEN SALAH ROBLEH

Certification Number: 50472 Expires: 08/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
NAS NURE
PERSON IN CHARGE

Signed: _____
Jeff Johanson