DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 9, 2023

Licensee
Golden Horizons
518 7th Avenue Northeast
Aitkin, MN 56431

RE: Project Number(s) SL30395015

Dear Licensee:

On October 31, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 12, 2022, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 27, 2023

Licensee
Golden Horizons
518 7th Avenue Northeast
Aitkin, MN 56431

RE: Project Number(s) SL30395015

Dear Licensee:

On September 22, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 12, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 12, 2022 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 12, 2022, found not corrected at the time of the September 22, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0480 - Minimum Requirements - 144g.41 Subd 1 (13) (i) (b) - $500.00
1290 - Background Studies Required - 144g.60 Subdivision 1 - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on September 22, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 218-332-5175.

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

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30395	A. BUILDING: _____ B. WING _____	R 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	518 7TH AVENUE NE AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL30395015-1 On September 18, 2023, through September 22, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 12, 2022. At the time of the survey, there were 41 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, correction orders 0480 and 1290 were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report, dated September 22, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{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	{0 680}		

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{0 680}	Continued From page 2 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: No further action required.	{0 680}		
{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	{0 790}		

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{0 790}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{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 by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	{0 810}		

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{0 810}	Continued From page 4 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the	{0 940}		

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{0 940}	Continued From page 5 housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 940}		
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation;	{01060}		

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{01060}	Continued From page 6 (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required	{01290}		

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{01290}	Continued From page 7 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was conducted and/or affiliated with the assisted living with dementia care license for three of three unlicensed personnel (ULP)-O, ULP-Q, ULP-R and two cooks (C)-N and C-P. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-O ULP-O was hired on May 2, 2023, to provide	{01290}		

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{01290}	Continued From page 8 assisted living services to licensee's residents. ULP-Q ULP-Q was hired on October 13, 2022, to provide assisted living services to licensee's residents. ULP-R ULP-R was hired on December 28, 2021, to provide assisted living services to licensee's residents. C-N C-N was hired on December 3, 2021, to provide assisted living services to licensee's residents. C-P C-P was hired on June 18, 2021, to provide services under the comprehensive home care license and continued to provide assisted living services to licensee's residents after August 1, 2021. On September 18, 2023, at 11:46 a.m., the surveyor requested to review the licensee's Netstudy 2.0 affiliation report. On September 18, 2023, at 1:01 p.m., the surveyor reviewed the Netstudy 2.0 affiliation report and found the above employees lacked evidence the licensee had conducted a background prior to the expiration of the prior temporary COVID-19 affiliated background study. Netstudy 2.0 indicated "eligible - COVID-19 Study - expired". The background study expiration date for staff noted above was December 31, 2022. On September 18, 2023, at 2:00 p.m., the surveyor and licensed assisted living director in residency (LALDIR)-B reviewed the employee's background studies in Net Study 2.0. ULP-O,	{01290}		

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{01290}	Continued From page 9 ULP-R, C-N and C-P had expired backgrounds as of December 31, 2022. ULP-Q's background indicated "in process" with an initiation date of September 18, 2023, the day of the survey visit. The surveyor asked LALDIR-B if all employees listed above were still active and working within the facility and if the employees had worked continuously since prior to and after the backgrounds expired. LALDIR-B stated, "yes, one of them [ULP-O] was hired this year " and she was unaware the backgrounds had expired, stating, "I had no idea". The surveyor asked who would be responsible for monitoring the backgrounds and assuring they were completed, LALDIR-B stated, "typically, that would probably be me. They just started having me do this last year". The licensee's Notice and Authorization for Release of Information for Criminal Background Check form, undated, indicated employees would undergo a criminal background check prior to employment. No further information was provided.	{01290}		
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	{01440}		

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{01440}	Continued From page 10 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action required.	{01440}		
{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. This MN Requirement is not met as evidenced by: No further action required.	{01750}		

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{01770}	Continued From page 11	{01770}		
{01770} SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: No further action required.	{01770}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30395	A. BUILDING: _____ B. WING _____	R 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	518 7TH AVENUE NE AITKIN, MN 56431

(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
{01910}	Continued From page 12 expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action required.	{02310}		

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

Type: Follow-Up
Date: *09/22/23*
Time: 11:00:00
Report: 6808231206

Food and Beverage Establishment Inspection Report

Location:

Golden Horizons
518 7th Avenue Ne
Aitkin, MN56431
Aitkin County, 01

Establishment Info:

ID #: 0039325
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186299960
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 previously issued on 10/11/22 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
SHAWN WEIMER IS CURRENTLY TAKING A CLASS. POST STATE CERTIFICATE ONCE RECEIVED.

Issued on: 10/11/22 *Comply By: 12/11/22*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHWSHER FINAL RINSE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH SOLUTION
Violation Issued: No

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

Type: Follow-Up
Date: *09/22/23*
Time: 11:00:00
Report: 6808231206
Golden Horizons

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 6808231206 of 09/22/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Lee Ann Austin
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us

Electronically Delivered

October 28, 2022

Administrator
Golden Horizons
518 7th Avenue Northeast
Aitkin, MN 56431

RE: Project Number(s) SL30395015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 12, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted no 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.

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

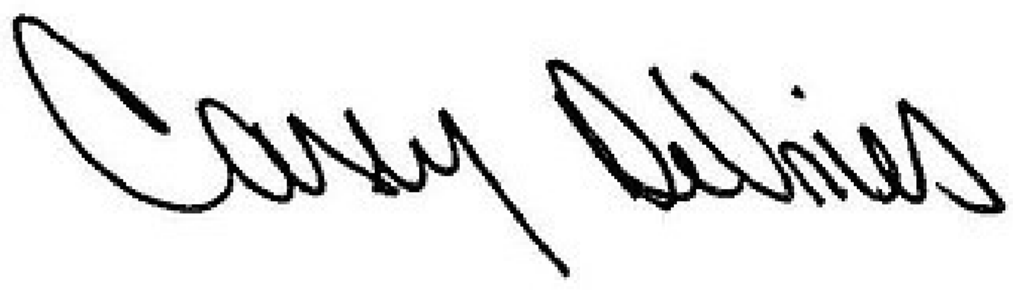
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30395	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	518 7TH AVENUE NE AITKIN, MN 56431

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30395015-0 On October 10, 2022, through October 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 42 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on October 11, 2022, issued for SL28989015-0, tag identification 1290. On October 12, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated October 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 tenant 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	0 680		

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0 680	Continued From page 3 licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on October 10, 2022, at 9:45 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided to and later reviewed by the surveyor. The licensee's plan included an updated hazard vulnerability assessment (HVA) which indicated 28 hazards (such as train derailment, chemical spill, tornado, flood, fire, power outage, pandemic, etc.) and scored each event based on probability, mitigation, and greatest threat. The licensee's emergency preparedness plan lacked the following content and/or policies and procedures to address: - arrangements/contracts to re-establish utility services; - the provision of subsistence needs for staff and residents; and - a description of the population served by the licensee.	0 680		

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0 680	Continued From page 4 On October 12, 2022, at approximately 11:21 a.m., LALD-A confirmed the licensee did not have an emergency plan with the required content. LALD-A stated licensee would add the information to licensee's emergency preparedness plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 had the potential to directly affect all residents and staff. 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	0 790		

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0 790	Continued From page 5 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 October 10, 2022, between 11:15 a.m. and 1:50 p.m., survey staff toured the facility with assistant (A)-B. During the facility tour, survey staff observed that monthly fire extinguisher inspections had not been documented after May 2022 on the fire extinguisher inspection tags. On October 10, 2022, during the exit interview at approximately 3:50 p.m., the licensed assisted living director (LALD)-A and A-B confirmed the findings and explained that a new employee had been recently hired for the maintenance position and that these inspections would be completed moving forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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 by: Based on observation and interview, the licensee	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 800	Continued From page 6 failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 October 10, 2022, between 11:15 a.m. and 1:50 p.m., survey staff toured the facility with assistant (A)-B. During the facility tour, survey staff observed the following: 1. Dementia Care Unit: a. Chemicals were stored in an unlocked cabinet under the kitchen sink in the resident serving kitchen. b. The bi-fold doors for a closet were damaged and not operating correctly in the dining room. c. The door handle and latch for the entrance door were missing in resident room 208. Additionally, the bottom piece of trim was missing from the window. d. A cover was not installed on an electrical box with exposed capped wires in the mechanical room. 2. Assisted Living: a. The door closer was disconnected for a storage room that was labeled as an office. b. Sprinklers were obstructed by food service items stored on shelving in the main kitchen dry storage area. c. The inspection tag for a backflow prevention device in the mechanical room was last dated	0 800		

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0 800	Continued From page 7 2013. d. One section of cove base was missing in the beauty salon. On October 10, 2022, during the exit interview at approximately 3:50 p.m., the licensed assisted living director (LALD)-A and A-B confirmed the findings. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 8 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required evacuation drill frequency. This had the potential to directly affect all residents and staff. 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 October 10, 2022, at 2:00 p.m., the licensed assisted living director (LALD)-A and assistant (A)-B provided documents for review. Documents were reviewed by survey staff on October 10, 2022, between 2:00 p.m. and 3:30 p.m. Evacuation drill reports dated 01/25/22, 04/07, 05/11/22, 07/06, and 08/01/22 were provided. The April and July reports were missing the year. The time or shift of the drills were not recorded for April, May, July, and August. Drill reports were not provided for February and March of 2022. On October 10, 2022, during the exit interview at approximately 3:50 p.m., the licensed assisted living director (LALD)-A and A-B confirmed that	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30395	A. BUILDING: _____ B. WING _____	10/12/2022

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0 810	Continued From page 9 the licensee failed to maintain records to support documentation for employee evacuation drill frequency of twice per year per shift with at least one evacuation drill every other month. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and	0 940		

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0 940	Continued From page 10 (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four (R1, R2, R3, R4) residents. 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: R1, R2, R3, and R4's assisted living contracts lacked disclosure of: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time and if so, the limit must be provided. R1 R1's Assisted Living Agreement Addendum Service Plan dated June 3, 2022, indicated the resident received medication management,	0 940		

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0 940	Continued From page 11 assistance with bathing, dressing and grooming, meal reminders, behavior redirection, safety checks, housekeeping, and laundry services. On October 11, 2022, at approximately 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-K provide dressing, grooming, and incontinence cares to R1. Later, ULP-K assisted R1 with coffee and breakfast. R1's Golden Horizons Residency Agreement was signed by R1 and R1's representative June 2, 2022. R2 R2's Assisted Living Agreement Addendum Service Plan, dated February 1, 2021, indicated the resident received medication management, assistance with bathing, meals, safety checks, housekeeping, and laundry services. On October 10, 2022, at approximately 1:06 p.m., the surveyor observed ULP-D administer medications to R2. R2's Golden Horizons Residency Agreement was signed by R2 on August 1, 2021. R3 R3's Assisted Living Agreement Addendum Service Plan, dated December 21, 2021, indicated the resident received medication management, assistance with bathing, meals, dressing, housekeeping, and laundry. On October 11, 2022, at approximately 7:55 a.m., the surveyor observed ULP-E measure R3's blood glucose level and subsequently administer insulin to R3. R3's Golden Horizons Residency Agreement was	0 940		

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0 940	Continued From page 12 signed by R3 on November 21, 2021. R4 R4's Service Plan, dated March 12, 2021, indicated the resident received medication management, assistance with bathing, transfers, toileting, safety checks, meals, dressing, housekeeping, and laundry. On October 11, 2022, at approximately 8:09 a.m., the surveyor observed ULP-E administer R4's morning medications. R4's Golden Horizons Residency Agreement was signed by R4 on September 1, 2021. On October 12, 2022, at approximately 11:40 a.m., licensed assisted living director (LALD)-A verified their current contract did not include language regarding the limit on the number of people at the facility who can get public assistance and added she did not know of any limit right now. LALD-A stated they updated their resident agreement this year and all residents would have the same contract. LALD-A said they would have to "take the contract back to the attorneys to look at." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of	01060		

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01060	Continued From page 13 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based interview and record review licensee failed	01060		

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01060	Continued From page 14 to ensure notice with required content was provided to the resident/representative for one of one resident (R1) who had an emergency relocation out of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted for assisted living with dementia care services on June 2, 2022. R1's Assisted Living Agreement Addendum, dated June 3, 2022, indicated R1 received medication management, assistance with bathing, dressing and grooming, meal reminders, behavior redirection, safety checks, housekeeping, and laundry. R1's progress notes between September 22, 2022, and September 30, 2022, indicated the following: -September 22, 2022, indicated licensee sent R1 to the emergency room for evaluation and a note later the same day indicated R1 was subsequently admitted to the hospital. -September 23, 2022, indicated a recommendation to place R1 for Geri psych (geriatric psychiatry) and the hospital agreed to place the resident. -September 28, 2022, indicated the hospital case manager reported R1 was declined for placement	01060		

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01060	Continued From page 15 at several nursing facilities. -September 30, 2022, indicated the facility had been in contact with the ombudsman, the hospital was unable to find R1 placement for a higher level of care and that R1 was discharged from the hospital and returned to the assisted living facility. Although R1 was relocated from the facility from September 22, 2022, to September 30, 2022, or eight days, R1's record lacked evidence a written emergency relocation notice was provided to the resident and resident's representative that at minimum contained: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On October 12, 2022, at approximately 11:51 a.m., licensed assisted living director (LALD)-A verified R1 was sent to the ER for evaluation on September 22, 2022, and that R1 remained hospitalized until R1 returned to the facility on September 30, 2022. LALD-A said she did not think of R1's stay initially as relocation and later confirmed neither R1 nor R1's POA (power of attorney) was provided a notice. LALD-A later said they were working with their electronic record provider to develop some kind of form for this	01060		

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01060	Continued From page 16 situation. The licensee's Emergency Relocation and Notice Policy, dated August 1, 2021, indicated the licensee may remove a resident from the facility in the event of an emergency, if necessary, due to urgent medical needs and that an emergency relocation is not a termination. The policy indicated the facility will provide written notice as soon as practicable to the resident, resident's representative, designated representative, office of Ombudsman and (if applicable) case manager and the notice would include the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care license for two of four employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate order for correction on October 11, 2022. The findings include: ULP-D ULP-D was hired on March 29, 2021, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021. On October 10, 2022, at approximately 1:06 p.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated March 9, 2021.	01290	On October 12, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread violation.	

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01290	Continued From page 18 ULP-E ULP-E was hired on June 24, 2020, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021. On October 11, 2022, at approximately 7:40 a.m., the surveyor observed ULP-E administer morning medications to R4. ULP-E's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated July 10, 2020. ULP-D and ULP-E's employee records lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care license, effective August 1, 2021. On October 11, 2022, at approximately 3:32 p.m., licensed assisted living director (LALD)-A stated the background studies for ULP-D and ULP-E were under the former, comprehensive license, with the same ownership, but not this assisted living facility. LALD-A stated during the conversion to assisted living licensure, "I was on maternity leave" and the task to take care of the background was delegated to the previous executive director and was not completed. On October 11, 2022, at approximately 4:15 p.m., the surveyor verified through Department of Human Services NetStudy 2.0 the following: - There was no cleared background study or pending application in NetStudy 2.0 for ULP-D under the licensee's name or license number. - There was a pending background study	01290		

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01290	Continued From page 19 application in NetStudy 2.0 for ULP-E under the licensee's name and license number, submitted by the licensee on October 10, 2022, however, the background study was not yet cleared. On October 11, 2022, at approximately 4:35 p.m., the surveyor informed LALD-A of the immediate correction order for lack of affiliated background studies for employees ULP-D and ULP-E, and that the employees either needed to be immediately removed from the schedule or be closely supervised by an employee with a cleared background study. The surveyor informed LALD-A this would need to be the case until ULP-D and ULP-E's background studies were cleared and affiliated with the licensee's current license. LALD-A said she would do a full in-house audit to begin this correction. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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	30395	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01440	Continued From page 20 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 calendar days of providing nursing services for one of two employees (unlicensed personnel (ULP)-E) with records reviewed. 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: ULP-E's employee record lacked documentation an RN supervised ULP-E performing a delegated task within 30 days of hire. On October 10, 2022, at approximately 1:53 p.m., the surveyor observed ULP-E administer R4 an as needed (PRN) medication.	01440		

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	30395	A. BUILDING: _____ B. WING _____	10/12/2022

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01440	Continued From page 21 ULP-E was hired on June 24, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 11, 2022, at approximately 1:48 p.m., licensed assisted living director (LALD)-A confirmed the RN had not completed a 30-day supervisory visit with ULP-E. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) included resident-specific instructions for the unlicensed staff to follow when administering as needed (PRN) medications for	01750		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 22 one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's electronic medication administration record (EMAR) lacked specific, written instructions, regarding the administration of PRN medications. R4's diagnoses included schizo-affective disorder, diabetes type II, and bipolar disorder. R4's service plan dated March 12, 2021, indicated R4 received services including medication administration. R4's Medication Administration Record, dated October 2022, included: acetaminophen 325 milligram (mg) tab take 1 - 2 tablets by mouth every four hours PRN. On October 10, 2022, at 1:53 p.m., the surveyor observed unlicensed personnel (ULP)-E administer R4 a PRN medication. ULP-E opened the locked medication cart and popped one pill each from two separate bubbles of a bubble pack (a foil backed, cardboard medication organizer) into a paper medication cup. ULP-E verified the medication in the EMAR. The surveyor asked ULP-E to show the surveyor where in the EMAR it provided instructions to administer one or two	01750		

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	30395	A. BUILDING: _____ B. WING _____	10/12/2022

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01750	Continued From page 23 pills when R4 requested a PRN. ULP-E showed the surveyor the instructions provided to ULP's. The instructions directed ULP's to administer 1-2 pills of the medication, however, did not provide resident-specific instructions or parameters to indicate under what circumstances ULP's were to provide 1 or 2 pills. Additionally, ULP-E stated, "she'll want two". The surveyor and ULP-E entered R4's room, ULP-E handed R4 the medication cup and R4 asked, "why did you give me two?" ULP-E responded to R4, "you can have two every four hours, do you only want one?" On October 10, 2022, at approximately 2:50 p.m., RN-C confirmed there were no specific instructions for R4's PRN medication and stated, " the new nurse entered that order. She must not know that we can't have ranges in the assisted living environment." The licensee's Medication Management Services policy updated July 1, 2022, indicated the RN must specify, in writing, in the electronic medication record, specific instructions for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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01770	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for one of one resident (R8). 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: During the entrance conference on October 10, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to include medication setup. R8's diagnoses included atrial fibrillation, diabetes type II, and hypertension (elevated blood pressure). R8's service plan dated June 18, 2021, indicated R8 received medication management services three (3) times daily. R8's electronic medication administration record (EMAR) dated October 2022, included the following medications: - alendronate 70 milligrams (mg) every Monday; - amlodipine 5 mg daily;	01770		

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01770	Continued From page 25 - folic acid 1 mg daily; - Furosemide 20 mg twice daily; - losartan 100 mg daily; - Prednisone 5 mg daily; - Metformin extended release (ER) 500 mg daily; and - Coumadin 2.5 mg Monday, Wednesday, and Friday. On October 12, 2022, at 9:32 a.m., the surveyor requested documentation for the setup of R8's medication caddie (a medication storage container that is divided into compartments organized by the days of the week and times of the day) to be administered by unlicensed personnel (ULP). Registered nurse (RN)-C stated, "I sign them off as a task in here" and showed the surveyor a medication setup task delegated to the RN within licensee's electronic records system. RN-C stated, "I don't sign off each med, it's just the task of setting up the medications. The staff sign off the Med Setup Summary when they administer the medication." Additionally, RN-C provided a Med Setup Summary dated October 1, 2022, to October 7, 2022, which included the initials of staff documenting when the medications were administered from the medication caddie and did not include documentation of the nurse setting up the medication caddie. R8's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration. The licensee's Medication Administration - Weekly Dosage Box Setup policy dated March 18, 2020, indicated the licensed nurse would	01770		

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01770	Continued From page 26 document the setup in the EMAR at the time the medications were setup into a dosage box. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to date time-sensitive medications with an opened-on date for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 10, 2022, at approximately 10:00 a.m., registered nurse (RN)-C stated licensee	01890		

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01890	Continued From page 27 provided medication management services for residents who received services. On October 10, 2022, at approximately 10:30 a.m., the surveyor reviewed medications in the locked medication cart with unlicensed personnel (ULP)-E. R3 R3's Anoro Ellipta Aerosol Powder Breath Activated 62.5-25 microgram (mcg) inhaler lacked labels to indicate the date staff removed the inhalers from the pouch and when the inhaler would expire. The manufacturer's instructions for the use of the Anoro Ellipta inhaler dated May 2021 directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. The directions also indicated the tray opened and discard dates should be written on the inhaler label. R4 R4's Advair 500-50 mcg/act inhaler lacked a label to indicate the date staff opened the inhaler from the box and when the inhaler would expire. The manufacturer's instructions dated January 2019 for the use of the Advair diskus inhaler directed for the inhaler to be discarded one month after being opened or when the counter reaches zero, whichever occurs first. On October 10, 2022, at approximately 11:30 a.m., licensed assisted living director (LALD)-A confirmed all time sensitive medications including the above noted time sensitive medications should be dated after opening with an open date and expiration date.	01890		

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01890	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of the disposition of medications included all required information for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

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01910	Continued From page 29 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's discharge - Transfer Summary, dated August 16, 2022, included assessment information, and indicated R5 received medication management services to include the administration of antidepressants and antipsychotic medications. The summary indicated R5's medications included the following: - multivitamin one time daily; - Lorazepam 0.5 milligram (mg) twice daily; - sertraline 50 mg one time daily; - vitamin B one time daily; and - vitamin D3 one time daily. R5's record lacked a medication disposition to include quantities of the medications, to whom the medications were given, and names of staff and other individuals involved in the disposition. On October 11, 2022, at approximately 10:16 a.m., licensed assisted living director (LALD)-A stated she was sure the medications were disposed of; however, LALD-A was unable to provide documentation for the disposition of the medications and stated, "no, I don't have anything other than the disposition summary I gave you." LALD-A confirmed the discharge summary was incomplete and did not include a medication disposition or statement of what was done with R5's personal belongings. LALD-A stated they should have documented the names and quantity	01910		

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01910	Continued From page 30 of the medications disposed. The licensee's Medication Destruction policy, dated March 18, 2020, indicated staff of the facility will dispose any medication, as needed, in a proper way, including following guidelines of the Minnesota Board of Pharmacy. Further, the policy directed, current unused medications managed by the facility will be returned to the pharmacy or given to the resident or representative and upon disposition, the facility must document in the resident's record the disposition, including name, strength, prescription number as appropriate, quantity, to whom the medication were given, date of disposition and names of staff and other individual involved in the disposition. The policy further indicated the medication disposition record would be kept on file at the facility for a minimum of two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of	02310		

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02310	Continued From page 31 oxygen. This had the potential to affect all 42 residents and staff. 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 October 10, 2022, at approximately 2:35 p.m., the surveyor observed 13 unsecured oxygen cylinders in and around R6's closet. Additionally, R6 had 12 secured oxygen tanks in his closet and one portable tank secured outside of his closet. R6 stated, "that's where they stay." On October 10, 2022, at 3:05 p.m., licensed assisted living director (LALD)-A stated she was unaware R6 had that many oxygen tanks in his room and confirmed it was the policy of licensee to secure all oxygen in appropriate storage containers. LALD-A stated, "we will call the oxygen supplier." The licensee's Oxygen policy dated March 18, 2020, indicated the licensed nurse would manage the proper storage and upkeep of the resident's oxygen systems in coordination with the appropriate medical equipment company of the resident's choice. The Minnesota Department of Health (MDH) utilizes guidance from the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code and directs that all oxygen	02310		

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02310	Continued From page 32 cylinders must be secured with chains or racks to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *10/11/22*
Time: 10:40:00
Report: 6808221178

Food and Beverage Establishment Inspection Report

Location:

Golden Horizons
518 7th Avenue Ne
Aitkin, MN56431
Aitkin County, 01

Establishment Info:

ID #: 0039325
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186299960
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

USE THE TABLETS. THE DISHWASHER AND THE LIQUID DISPENSER IS NOT WORKING AT THIS TIME.

Comply By: 10/11/22

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.

PROVIDE A QAC TEST KIT FOR THE TABLET AND LIQUID SANITIZERS

Comply By: 10/12/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Comply By: 12/11/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HAVE THE DISHWASHER SANITIZING CYCLE REPAIRED.

Comply By: 10/14/22

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

STORE ALL SINGLE SERVICE ARTICLES OFF THE FLOOR IN THE DRY STORAGE CLOSET IN THE MEMORY CARE UNIT.

Comply By: 10/14/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH SOL. =4 TABLETS
Violation Issued: No

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: DISPENSER SANITIZER AT THREE COMP SINK
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: PUDDING IN MAIN KIT. UNIT
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: BOTH MEMEORY CARE REFRIGERATORS
Violation Issued: No

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

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 6808221178 of 10/11/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Signed:_____
Establishment Representative

Signed:_____

Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us