Electronically Delivered

April 3, 2024

Licensee
Golden Nest LLC
6733 Emerson Avenue South
Richfield, MN 55423

RE: Project Number(s) SL23666015

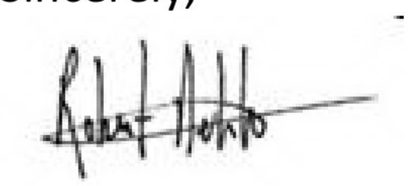
Dear Licensee:

On March 15, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 5, 2024, survey were corrected. This follow-up survey verified that the facility is back 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,



Bob Dehler, Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710 Fax: 1-866-890-9290

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February 2, 2024

Licensee
Golden Nest LLC
6733 Emerson Avenue South
Richfield, MN 55423

RE: Project Number(s) SL23666015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose 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. MDH 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 (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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

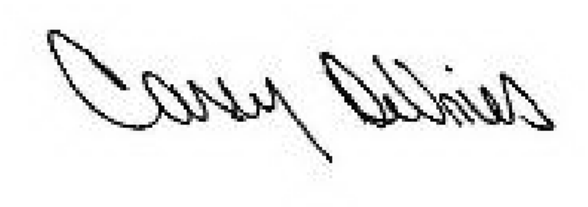
Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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
	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	6733 EMERSON AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23666015-0 On January 2, 2024, through January 5, 2024, 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 six residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on January 4, 2024, issued for SL23666015-0, tag identification 0820. On January 8, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of G.	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 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: (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 (FBEIR), dated January 2, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of one observed staff (unlicensed personnel (ULP)-C). 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-C was hired September 15, 2010, and provided direct care services to residents of the licensee. On January 2, 2024, at 1:03 p.m., the surveyor observed ULP-C administer medications to R5. ULP-C performed HH by turning on water, adding	0 510		

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0 510	Continued From page 3 soap, and rubbing hands together under the running water stream for 12 seconds. ULP-C shut the water off with a bare hand, then dried. After administering the medications to R5, ULP-C again performed HH, rubbing hands together underneath the running water stream for 10 seconds, then shut off the water with a bare hand and then dried. ULP-C did not wash hands for at least 15 seconds or turn off the water faucet using a paper towel, as recommended by CDC guidelines. On January 2, 2024, at 2:05 p.m., the surveyor observed ULP-C administer oral medications to R6 and R4. ULP-C performed HH appropriately, administered medications to R6 in her room, then documented. ULP-C, without performing HH, proceeded to gather medications for R4, then administered them in R4's room. ULP-C documented the medication administration, and performed appropriate HH. On January 2, 2024, at 1:08 p.m., ULP-C stated they attended annual training which included HH. ULP-C stated she was taught to wash hands for 10 seconds, not at least 15 seconds as recommended by CDC guidelines. On January 3, 2024, at 2:32 p.m., clinical nurse supervisor (CNS)-A stated she had not seen deficient HH practices during her observations of staff, and the topic of HH had been discussed frequently, and staff were trained to wash for 20 seconds. CNS-A further stated she would expect HH to be performed between administering medications to different residents. The CDC guidance, Hand Hygiene in Health Care Settings, revised January 8, 2021, indicated, "When cleaning your hands with soap and water,	0 510		

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0 510	Continued From page 4 wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet." The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Infection Control policy, dated August 1, 2021, indicated, "The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control." The policy further indicated hand hygiene should be completed before assisting a resident with medications. No further information was provided.	0 510		

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0 510	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as 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 employee records included all required content for one of two employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 6 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-A was hired December 5, 2022, to provide direct care services for residents as well as training and supervision for employees. CNS-A's employee record lacked documentation of the required initial orientation to Assisted Living. On January 2, 2024, at 11:14 a.m., licensed assisted living director (LALD)-B stated she knew CNS-A completed all orientation topics, and there was a certificate they would print out in addition to the checklist, but she (LALD) probably forgot to document that for CNS-A. On January 2, 2024, at 1:32 p.m., CNS-A stated she did have the required initial orientation upon hire. CNS-A stated possibly because she was in a leadership role, the person responsible for documenting training did not realize it needed to also be documented for her. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated, "No one may provide direct care to residents on behalf of [Licensee] before successfully completing the organization's orientation program." The policy further indicated, "Upon completion of the orientation, the signed/dated Orientation Checklist will be retained in the employee record".	0 650		

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0 650	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes: baseline testing, symptom and history screening, and education on recognizing the signs and symptoms of TB, for one of two employees (Clinical Nurse Supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 660	Continued From page 8 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: The facility TB risk assessment completed March 22, 2022, indicated the facility was at a low risk for TB transmission. CNS-A was hired December 5, 2022, and provided direct care services for residents, and training and supervision for employees. CNS-A's employee record included a single step TB skin test (TST) result dated November 4, 2022. CNS-A's record lacked documentation of a second step TST, history and symptom screening, and TB infection control training completed upon hire. On January 2, 2024, at 12:41 p.m., licensed assisted living director (LALD)-B stated only the 1-step TST was documented in the employee file. LALD-B further stated all of orientation topics including TB infection control were covered with CNS-A, but was unsure where it was documented. -at 12:48 p.m., LALD-B stated the TB history and symptom screening form for CNS-A would be at another office location. LALD-B stated CNS-A verified she did not complete a second-step TST, but completed a TB blood test, and would need to get the documentation from her clinic record. On January 3, 2024, at 2:13 p.m., CNS-A stated	0 660		

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0 660	Continued From page 9 she had a single TST upon hire, and did not know a second step was required. CNS-A stated she had orientation to include TB infection control. CNS-A further stated she thought the history and symptom screening form was only for employees who had a history of a positive TB test. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated, "Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three	0 660		

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0 660	Continued From page 10 components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	6733 EMERSON AVENUE SOUTH RICHFIELD, MN 55423

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0 680	Continued From page 11 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document annual review and updates to the emergency preparedness (EP) plan and hazard vulnerability assessment (HVA). 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 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 EP plan, documented as last reviewed and updated March 30, 2022, lacked documentation it was reviewed within the past year. The licensee's HVA, documented as last reviewed September 12, 2022, lacked documentation it was reviewed within the past year. On January 3, 2024, at 12:50 p.m., licensed assisted living director (LALD)-B stated the administrative staff that usually reviews the EP had been on leave, and the task did not get completed on time. The licensee's Emergency Preparedness policy,	0 680		

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0 680	Continued From page 12 dated August 1, 2021, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." 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 perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 13 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 4, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the tour, it was observed the fire extinguisher on the lower level did not have a service tag showing it had been inspected annually and lacked records to show the required monthly visual inspections were performed. It was also observed the installed fire extinguisher on the lower level was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. On January 4, 2024, at 10:00 a.m., LALD-B verified the fire extinguisher in the lower level was not an appropriate-sized fire extinguisher and was not maintained. 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,	0 800		

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0 800	Continued From page 14 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment 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 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 4, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following: In the resident sleeping room #2 on the main level, it was observed the window was shut tight, and LALD-B could not push it open when attempted. Maintenance staff (MS)-E had to remove the window locking handle from the inside to open the window.	0 800		

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0 800	Continued From page 15 On January 4, 2024, at 10:00 a.m., LALD-B stated exterior windows were stuck due to exterior painting being painted over the window frame, and confirmed the egress window openings were obstructed. In the resident sleeping room #4 on the main level, it was observed the window crank handle was stripped, and we could not open the window. LALD-B could not locate the window crank handle and confirm the deficiency. 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.	0 810		

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0 810	Continued From page 16 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. 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, 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 4, 2024, at 12:00 p.m., license assisted living director (LALD)-B provided documentation on the fire safety and evacuation	0 810		

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0 810	Continued From page 17 plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP did not show the location and number of resident rooms. The posted emergency evacuation plans were not accurate depictions of the egress route and did not match the current layout of the facility. In the posted emergency evacuation plan, it was observed the location of resident sleeping rooms #3, #4, #5, and #6 and the seating space behind the kitchen were not shown. During the interview on January 4, 2024, at 12:00 p.m., LALD-B stated the facility remodeled the building and added a new wing, but the emergency evacuation plans were not modified to show the updated layout and location of resident rooms. In the posted main-level emergency evacuation plan, the egress route from the main level was marked through to the stair door leading to a lower level, but the stair door was locked with a code from the main level side. During the interview on January 4, 2024, at 12:00 p.m, LALD-B stated all staff have access to the key for the door, but residents do not have access to the key. LALD-B stated they do not use the stair door as an emergency exit, and the evacuation plan was not accurate. TRAINING Record review of the available documentation indicated employees did not receive training twice	0 810		

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0 810	Continued From page 18 per year after initial hire. During the interview on January 4, 2024, at 12:00 p.m., LALD-B stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-B confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted every other month but provided only for the morning shift and failed to provide two drills for the afternoon and the night shift. During the interview on January 4, 2024, at 12:00 p.m., LALD-B stated all drills were conducted in the morning with all three shifts attended and confirmed the facility did conduct two drills for the afternoon and the night shift. LALD-B verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use	0 820		

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0 820	Continued From page 19 does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #1 on the main level. 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 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 4, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #1 on the main level did not have windows that	0 820	This immediate correction order identified on January 4, 2024, had the immediacy removed on January 8, 2024, however non-compliance remained at an scope and level of G. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 20 met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 49 inches in height and 16.5 inches in width, with a total openable area of 808 square inches. The windows did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-B that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-B verbally confirmed the findings. On January 4, 2024, at 11:30 a.m., survey staff explained to LALD-B that an immediate correction order was issued for the above finding. LALD-B acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management	0 900		

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0 900	Continued From page 21 agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were no non-contracted residents living in the building (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 900		

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0 900	Continued From page 22 The findings include: ULP-D was hired February 17, 2015, and provided direct cares for residents. On January 4, 2024, at 11:55 a.m., engineer surveyor (S)-F notified the surveyor of a staff member (ULP-D) living in the lower level of the facility. On January 4, 2024, at 12:18 p.m., licensed assisted living director (LALD)-B identified ULP-D as the staff member living in the lower level of the facility. LALD-B stated ULP-D had lived in the facility for approximately six to seven years. ULP-D did not have a signed assisted living contract for the licensee's facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 23 (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: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 24 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's record lacked documentation of emergency relocation provided by the licensee following hospitalization. R1 diagnoses included dementia and high blood pressure. R1's Service Plan dated March 22, 2022, indicated R1 received services including medication administration, assistance with dressing and grooming, laundry, and cleaning. R1's discharge summary, dated May 13, 2023, indicated R1 was discharged due to death. On January 3, 2024, at 1:18 p.m., clinical nurse supervisor (CNS)-A stated R1 was sent to the hospital on April 24, 2023, and upon discharging from the hospital 18 days later, on May 12, 2023, was admitted to the licensee's other assisted living location. CNS-A stated she was not aware of any notification sent to the OOLTC. CNS-A further stated there was an employee that performed administrative tasks from home that might have sent the notification. On January 5, 2024, at 3:40 p.m., via email, the OOLTC ombudsman assigned to the facility indicated, "I could not find any notices sent to our	01060		

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	23666	A. BUILDING: _____ B. WING _____	01/05/2024

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01060	Continued From page 25 office from [licensee] - on this resident [R1] or any other." The licensee's Discharge and Transfer of Residents policy, dated August 1, 2021, indicated, "In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to [licensee] within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	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	01290		

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01290	Continued From page 26 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 observation, interview, and record review, the licensee failed to ensure a department of human services (DHS) NETStudy 2.0 background study was submitted and a clearance received in affiliation with the assisted living license for two of three employees (unlicensed personnel (ULP)-C, and ULP-D). 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: ULP-C was hired September 15, 2010, and provided direct care services to residents of the licensee. On January 2, 2024, the surveyor observed ULP-C administer medications to R4, R5, and R6. ULP-D was hired February 17, 2015, and provided direct care services to residents of the licensee. ULP-C and ULP-D's employee records each included a DHS background study clearance form, dated November 22, 2011 and January 23, 2015, respectively. The clearance forms indicated	01290		

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01290	Continued From page 27 the background study was for the facility, "Agency ID 23665". ULP-C and ULP-D's employee records lacked evidence of a cleared background study affiliated with the licensee's current assisted living HFID (23666). On January 2, 2024, at approximately 1:00 p.m., the DHS NETStudy 2.0 database indicated ULP-C and ULP-D were not listed in the employee background study roster for the licensee's HFID (23666). On January 2, 2024, at 1:15 p.m., licensed assisted living director (LALD)-B stated the HFID 23665, from ULP-C and ULP-D's background study forms, was the HFID of a comprehensive license she owned. LALD-B stated she was the sensitive information person (SIP) and still had access to the active NETStudy roster for HFID 23665. LALD-B stated she thought she would still be notified of any changes to the employee background study record. LALD-B added she did not think she needed to initiate a new background study for employees hired prior to the new licensure taking effect August 1, 2021. LALD-B showed the surveyor a NETStudy 2.0 employee roster for another assisted living HFID owned by the licensee, which included several employees who were hired prior to August 1, 2021. LALD-B stated they were transferred by DHS to the assisted living facility roster, so she thought all employees had been transferred. The licensee's Recruitment and Hiring Policy, dated December 23, 2022, indicated, "For Unlicensed Staff and Licensed Staff who have not completed a fingerprint background study: The Criminal Background Check will be submitted to	01290		

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01290	Continued From page 28 Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 29 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01470		

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01470	Continued From page 30 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired September 15, 2010, and provided direct cares for residents. On January 2, 2024, at 1:03 p.m., the surveyor observed ULP-C administer medications to R5. ULP-C's employee record lacked documentation the following orientation topics were completed: -Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; -Review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; -Review of the types of assisted living services the employee will provide, and the provider's scope of license; and -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. On January 3, 2024, at 9:15 a.m., licensed assisted living director (LALD)-B stated they set up a block of four to five hours of orientation led by the house manager, LALD-B, or clinical nurse supervisor (CNS)-A. LALD-B further stated they tracked the orientation using a checklist. The licensee's Staff Orientation and Education policy, revised August 1, 2021, indicated, "All staff providing assisted living through [Licensee] will be prepared to provide safe, effective services to all	01470		

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01470	Continued From page 31 residents through a thorough orientation and education program pertinent to the needs of the residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500		

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01500	Continued From page 32 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of training for each 12 months of employment for one of two employees (clinical nurse supervisor (CNS)-A). 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	01500		

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01500	Continued From page 33 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: CNS-A was hired December 5, 2022, to provide direct care services for residents as well as training and supervision for employees. CNS-A's employee record lacked documentation of the required eight hours of annual training, including the following topics: -Reporting of maltreatment of adults; -Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; -Review of the organization's policies and procedures related to provision of assisted living services and how to implement them; -Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders; and -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. On January 2, 2024, at 9:15 a.m., licensed assisted living director (LALD)-B stated they provided annual training in increments throughout the year. LALD-B stated CNS-A should have completed all required training, but possibly was not documented. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated, "All staff providing assisted living services will complete at	01500		

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01500	Continued From page 34 least eight (8) hours of education for every twelve (12) months of employment." The policy further indicated, "Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC***** ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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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 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 the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a	01530		

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01530	Continued From page 36 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: CNS-A was hired December 5, 2022, to provide direct care services for residents as well as training and supervision for employees. CNS-A's employee record lacked documentation of the required initial eight hours of dementia care training in the following topics: -An explanation of Alzheimer's Disease and other dementias; -Assistance with activities of daily living; -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. CNS-A's employee record further lacked documentation of the required two hours annual dementia training for every 12 months of employment. On January 3, 2024, at 11:14 a.m., licensed assisted living director (LALD)-B stated CNS-A completed initial and annual dementia care training, and that the documentation would be located in a training binder. The documentation was not provided. On January 3, 2024, at 1:32 p.m., CNS-A stated she completed initial training, and participated in providing annual dementia care training to employees around April 2023. CNS-A stated possibly the licensee did not realize the training	01530		

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01530	Continued From page 37 needed to be documented for her. On January 5, 2024, at 10:49 a.m., LALD-B provided, via email, an example of the dementia care training materials used. The provided materials lacked the following required dementia care topics: -Assistance with activities of daily living; -Problem solving with challenging behaviors; and -Person-centered planning and service delivery. The licensee's Dementia Education policy, dated August 1, 2021, indicated, "Direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADLs) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery." The policy further indicated, "Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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01640	Continued From page 38 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided. Additionally, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of two 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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	6733 EMERSON AVENUE SOUTH RICHFIELD, MN 55423

(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
01640	Continued From page 39 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 had diagnoses including type 2 diabetes and high blood pressure. R2's initial service plan, dated June 21, 2023, indicated R2 received services including assistance with dressing, grooming, toileting, medication management, housekeeping, and laundry. Additionally, the service plan indicated monthly blood glucose (BG) monitoring. On January 3, 2024, at 8:50 a.m., the survyeor observed unlicensed personnel (ULP)-C assist R2 with BG monitoring. R2's record included documentation of daily BG readings from September 11, 2023, through December 30, 2023. R2's record included physician orders, dated October 6, 2023, indicating daily BG monitoring for R2. R2's record lacked an updated service plan to reflect the current services provided, daily BG monitoring. On January 3, 2024, at 12:50 p.m., licensed assisted living director (LALD)-B stated service plans were completed by clinical nurse supervisor (CNS)-A and updates would be her duty. On January 3, 2024, at 1:32 p.m., CNS-A stated she did not have an updated service plan signed by R2.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 40 The licensee's Service Plan policy dated August 1, 2021, indicated, "Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment." The policy further indicated, "The service plan must be revised, if needed, based on resident review or reassessment" and "The initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 41 one of two 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 had diagnoses including type 2 diabetes and cognitive impairment. R4's service plan dated August 1, 2021, indicated R4 received services including assistance with medication management and blood glucose (BG) monitoring. On January 3, 2024, at 8:08 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R4 with BG monitoring. R4's record lacked a current signed order for BG monitoring. On January 3, 2024, at 1:32 p.m., clinical nurse supervisor (CNS)-A stated they usually get a medication list signed by the provider annually. CNS-A further stated she thought that would include the BG monitoring order. The licensee's Treatment and Therapy Management policy, dated August 1, 2021, indicated, "The RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23666	A. BUILDING: _____ B. WING _____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	6733 EMERSON AVENUE SOUTH RICHFIELD, MN 55423

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01970	Continued From page 42 include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided c. Frequency d. Other pertinent information" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/02/24*
Time: 11:00:00
Report: 1013241001

Food and Beverage Establishment Inspection Report

Location:
Golden Nest Llc
6733 Emerson Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038639
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517552836
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.

7-200 Toxic Supplies and Applications

7-207.11B ***** Priority 1 *****

MN Rule 4626.1660B Label and locate personal medications in areas that do not contaminate food, equipment, linens, and single-service and single-use articles.

NUMEROUS MEDICATIONS (LIQUID AND PILLS) WERE STORED DIRECTLY NEXT TO CLEAN PLATES LOCATED IN A KITCHEN CABINET. DISCUSSED MEDICATION STORAGE WITH STAFF AND THE MEDICATIONS WERE REMOVED.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER WAS AVAILABLE. RAW MEATS ARE COOKED AND TCS FOOD IS STORED ON-SITE. DISCUSSED THERMOMETER USE WITH STAFF.

Comply By: 01/08/24

2-100 Supervision

2-102.12AMN

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

NO MN CFPM WAS EMPLOYED AT THE FACILITY. ONE STAFF HAD A FOOD MANAGER'S COURSE CERTIFICATE. COMPLY WITH ABOVE RULE. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 03/02/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

RICE SCOOP WAS STORED INSIDE THE BULK RICE CONTAINER WITH THE HANDLE DIRECTLY IN CONTACT WITH THE FOOD. DISCUSSED UTENSIL STORAGE WITH STAFF AND THE UTENSIL WAS MOVED SO THE HANDLE WAS AWAY FROM THE FOOD.

Corrected on Site

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Frozen meal
Temperature: 30 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Sausage
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator R. Anderson.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, linoleum floor, painted walls, solid laminate counter top, and a painted ceiling.

A two basin sink was located in the kitchen. One basin was designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Type: Full
Date: *01/02/24*
Time: 11:00:00
Report: 1013241001
Golden Nest Llc

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 1013241001 of 01/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Hongjoo Lee
Operator

Signed:_____
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us