DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 20, 2024

Licensee
Golden Bay Homes
2700 62nd Street East
Inver Grove Heights, MN 55076

RE: Project Number(s) SL25528016

Dear Licensee:

On March 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 18, 2024, survey were corrected. This follow-up survey verified that the facility is in sustantial 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,

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

PMB

Electronically Delivered

February 23, 2024

Licensee
Golden Bay Homes
2700 62nd Street East
Inver Grove Heights, MN 55076

RE: Project Number(s) SL25528016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 18, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25528	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BAY HOMES	2700 62ND STREET EAST INVER GROVE HEIGHTS, MN 55076

(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: SL25528016-0 On January 16, 2024, through January 18, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were four residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on January 16, 2024, issued for SL25528016-0, tag identification 1290. On January 17, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on January 17, 2024, issued for SL25528016-0, tag	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.	

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0 000	Continued From page 1 identification 2310. On January 18, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH). The licensee provided a backdated document for a bedrail assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 330		

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0 330	Continued From page 2 The findings include: Minnesota (MN) Statute 144G.30, Subd. 4, indicated the assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. On January 17, 2024, at approximately 9:45 a.m., owner (O)-G provided surveyors a handwritten Side-Rail Use Assessment Form for R1, which was completed on January 16, 2024, and backdated to March 9, 2023. On January 17, 2024, at 10:18 a.m., registered nurse (RN)-A stated R1's bedrail was removed and put back on by a family member. RN-A stated unlicensed personnels (ULPs) were educated multiple times to report bedrail use, but none of the ULPs reported R1 had bedrails on their bed. RN-A stated no bedrail assessment was done since March 9, 2023. On January 17, 2024, at 10:38 a.m., the surveyor inquired for the timeline when R1 was admitted, when the bedrail was put on, when the family removed it, and when it was put back on. RN-A stated R1 was admitted on March 9, 2023, with no bedrails. RN-A stated they completed R1's 14-day assessment on March 23, 2023, in person, and there were no bedrails. RN-A then stated the bedrail assessment dated March 9, 2023, was completed on January 16, 2024, and it was backdated to March 9, 2023. RN-A stated "I knew you guys were not stupid" when they explained why they backdated the document. RN-A stated there were no bedrail assessments completed until January 16, 2024. On January 17, 2024, at 10:48 a.m., ULP-B	0 330		

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0 330	Continued From page 3 stated R1 had the bedrail since she arrived at the facility. ULP-B stated she was not educated to report bedrail use to the RN. On January 17, 2024, at 10:51 a.m., R1 stated they had the bedrails for several years and they had it since their admission. R1 stated they signed the Side-Rail Use Assessment Form on January 16, 2024. The surveyor inquired if R1 knew the form was backdated to March 9, 2023. R1 stated RN-A told them the form was backdated because R1 had the bedrail since admission, but it had not been caught until January 15, 2024. The form had the date filled in by the RN. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	0 330		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 4 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. 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 held an assisted living license and was licensed for a bed capacity of six residents and had a current census of four residents. On January 16, 2024, at 12:55 p.m., registered nurse (RN)-A and licensed assisted living director	0 470		

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0 470	Continued From page 5 (LALD)-D stated they did not have a staffing plan. They said they did plan for their staffing needs regularly but they did not do a formal staffing plan which was revised twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving, hand drying towels, and hand hygiene. 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	0 510		

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0 510	Continued From page 6 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was a two-level rambler style home with a main floor and a basement. There was a bathroom on the main level just off the kitchen and a second bathroom in the basement at the bottom of the stairs. The bathrooms were for use by all four residents, staff, and visitors. On January 16, 2024, at 11:00 a.m., during the facility tour the surveyor observed two folded hand towels sitting on the countertop and a washcloth hanging on the towel rail in the first floor bathroom. The surveyor also observed there were no paper towels or toilet paper in the bathroom. Owner (O)-G stated they do not use paper towels due to a resident's hording behavior. O-G stated residents do not share towels, but one resident uses the same towel throughout the day. On January 17, 2024, at 7:50 a.m., the surveyor observed ULP-B providing morning cares to R1. ULP-B applied gloves, helped R1 get out of bed and walked with R1 to the bathroom which was located outside of R1's room, across the hallway and shared with other residents. Without changing gloves, ULP-B opened the bathroom door, helped R1 to sit on the toilet, and assisted R1 with peri cares. The surveyor observed two clean towels on the countertop in the bathroom and a washcloth hanging on the towel rail. ULP-B gave a clean washcloth to R1. R1 washed their face and gave the dirty washcloth to ULP-B. ULP-B gave another clean towel to R1 with her right hand and held the dirty washcloth with her	0 510		

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0 510	Continued From page 7 left hand. R1 dried their hands and face and put the towel back on the counter. Without changing gloves, ULP-B touched R1's walker, opened the bathroom door for R1 to go to the next room, where ULP-B helped R1 get weighed. ULP-B then removed the gloves and applied a new pair of gloves without performing hand hygiene. ULP-B walked R1 back to their room, made the bed, helped R1 with changing clothes, applied a boot to R1's left foot and orthotic brace to R1's right leg. ULP-B touched R1's water bottle, phone, and purse without removing the gloves or performing hand hygiene. ULP-B took R1's comb to the bathroom to wet it, came back to R1's room, combed R1's hair, touched and fixed R1's eyeglasses, helped R1 walk out of the bedroom and onto the sliding chair to go upstairs to the dining room without changing gloves or performing hand hygiene. ULP-B carried R1's water bottle and purse to the dining table on the first floor and opened the gate for R1. ULP-B pulled a chair for R1 to sit at the dining table and removed the gloves but did not perform hand hygiene. ULP-B then removed a breakfast bowl and a glass off the dining table and brought to the kitchen sink where the surveyor then observed ULP-B perform hand hygiene. On January 17, 2024, at approximately 9:00 a.m., ULP-B stated they received an online infection control training course about three months ago. ULP-B stated they were not told to not wear gloves in the hallway. ULP-B further stated they were supposed to change gloves and perform hand hygiene in between cares but they did not do it. On January 17, 2024, at 2:08 p.m., registered nurse (RN)-A stated the ULPs are supposed to change gloves and perform hand hygiene in	0 510		

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0 510	Continued From page 8 between cares. RN-A stated residents share hand towels, and it is ok for the residents to share hand towels as long as they do have open wounds or cuts. The CDC Guideline for Hand Hygiene in Healthcare Settings on the CDC website last reviewed on January 8, 2021, read, "The CDC Guideline for Hand Hygiene in Healthcare Settings [PDF - 1.3 MB] recommends: -When cleaning your hands with soap and water, 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. -Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." The CDC Guideline for Hand Hygiene Guidance in Healthcare Settings on the CDC website last reviewed on January 20, 2020, read, "The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient	0 510		

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0 510	Continued From page 9 -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices -Before moving from work on a soiled body site to a clean body site on the same patient -After touching a patient or the patient's immediate environment -After contact with blood, body fluids, or contaminated surfaces -Immediately after glove removal Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. The licensee's Annual Training Including Infection Control policy and procedure revised on January 18, 2023, read, "d. Infection control techniques used in the home and implementation of infection control standards including: i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades	0 510		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 10 iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	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 observation, interview, and record	0 650		

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	25528	A. BUILDING: _____ B. WING _____	01/18/2024

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0 650	Continued From page 11 review, the licensee failed to ensure the registered nurse (RN) completed training and competency for unlicensed personnel (ULP) providing medications to residents for unplanned times away from home when the licensed nurse was not available for two of two employees (ULP-B, ULP-E). 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: ULP-B ULP-B was hired on February 8, 2008, to provide direct cares to residents. On January 17, 2024, at approximately 8:30 a.m., the surveyor observed ULP-B administer medications for R1. ULP-B's employee record included a Relias (online training platform) transcript which lacked training for administering medications to residents for unplanned time away. ULP-E ULP-E was hired on December 2, 2023, to provide direct cares to residents. ULP-E's employee record included a Relias (online training platform) transcript which lacked training for administering medications to residents	0 650		

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0 650	Continued From page 12 for unplanned time away. ULP-B and ULP-E's employee records both lacked documentation of training and competencies for unplanned times away when the RN was not available. On January 17, 2024, at 12:04 p.m., ULP-B stated they received training for unplanned times away and was able to walk the surveyor through the process of setting up medications. On January 17, 2023, at 12:09 p.m., owner (O)-G stated they did not have documentation for unplanned times away training for any of their ULPs. O-G stated they believed the training had been completed prior to taking ownership of the licensee. O-G stated ULP-F was the primary staff member to setup medication for unplanned times away in the event of an emergency as ULP-F lived nearby and could come to the facility as needed. O-G stated only ULP-F and registered nurse (RN)-A were able to setup medications for unplanned times away and no other staff were trained or allowed to perform the task. O-G stated they did not have documented training for unplanned times away for any of their ULPs. On January 18, 2023, at 3:10 p.m., RN-A stated only a few ULPs were trained to setup medications for unplanned times away, otherwise, they (RN-A) would come to the facility to do it. RN-A stated if they trained all of their ULPs and they didn't perform the task after a few months then the ULPs would lose the skill and need to be retrained. The licensee's Medication Management for Residents Away from Home policy, date updated to the date the file was opened as having been	0 650		

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0 650	Continued From page 13 revised, indicated: "Unplanned Absences The Golden Bay Homes RN shall give the medications to the resident or resident's representative in amounts and dosages needed for the length of anticipated absence, not to exceed 120 hours. If the RN is not available, the RN can delegate this task to unlicensed staff that is competent to follow procedures for administering medication to a resident." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	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 observation, interview, and record	0 660		

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0 660	Continued From page 14 review, the licensee failed to ensure a facility tuberculosis (TB) risk assessment was completed annually. Further, the licensee failed to ensure TB symptom screening was completed at the time of hire and TB training was completed annually and at the time of hire for one of two employees (registered nurse (RN)-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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB Risk Assessment was completed during survey on January 16, 2024, and indicated the facility was at a low risk for TB transmission. RN-A was hired on June 21, 2017, to provided direct cares to residents and oversite to unlicensed personnel (ULP). On January 16, 2024, at 12:55 p.m., the surveyor observed RN-E managing resident insulin pens. RN-A's record lacked the following: -TB history and symptom screening at the time of hire; -TB training at the time of hire; and -TB annual training. On January 16, 2024, at 12:55 p.m., RN-A stated it was their responsibility to complete the licensee's TB risk assessment but was unsure	0 660		

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0 660	Continued From page 15 when it had last been completed. On January 17, 2024, at 10:00 a.m., owner (O)-G stated they did not have record of a completed TB history or symptom screening for RN-A. O-G stated they were aware of the TB history and symptom screening requirements, but they were not completed by the previous owner of the licensee. On January 17, 2024, at 11:37 a.m., the surveyor inquired via email if O-G had a TB risk assessment completed prior to the one completed on January 16, 2024. Later at 11:48 a.m., O-G's email response indicated, "I do not, under the Golden Bay Homes Ownership. Previous owners did not have one on file." On January 18, 2024, at 1:48 p.m., O-G stated they created their current TB risk assessment on January 16, 2024, during the survey with RN-A. O-G stated they inquired with the previous owner, licensed assisted living director (LALD)-D, to see if they had a copy of their most recent TB risk assessment but they did not have one to provide. O-G stated they did not have record of initial or annual TB training for RN-A. O-G stated they oversaw assigning annual trainings and used Relias (online training platform) to make sure trainings were completed. O-G stated TB training had not been assigned to RN-A in Relias. O-G stated they were familiar with the TB training requirements but was not aware of how frequently it needed to be completed, "but I'm learning it now." On January 18, 2024, at 2:08 p.m., RN-A stated they had not completed TB initial or annual training. RN-A stated they asked ownership if they needed to complete any TB training but nobody	0 660		

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0 660	Continued From page 16 ever told them what they were required to complete. RN-A stated TB training would have been completed in Relias if it was done. RN-A stated they had TB history and symptom screening completed when they were hired but did not have documentation to show it had been completed. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Minnesota Department of Health TB FAQ indicated each provider licensed by MDH is required to complete a TB risk assessment annually. Further, all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. The licensee's Tuberculosis Prevention Control Plan dated June 30, 2023, indicated, "The Golden Bay Homes RN is responsible for TB infection-control program which will be evaluated annually to ensure that Golden Bay Homes remains one in which persons who have suspected or confirmed TB disease are not encountered and that they are promptly transferred." It further indicated, "Baseline TB screening for all new Golden Bay Homes employee's twice yearly. A TB test or chest x-ray upon hire or proof of negative 2-step TB skin test, Quantiferon Gold test or chest x-ray within the last 12 months. If a Quantiferon-TB Gold test was done, new 2 step test every 2 years is not necessary. Employees will receive TB training yearly."	0 660		

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0 660	Continued From page 17 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 18 content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 emergency disaster preparedness plan, revised on June 30, 2023, lacked evidence of the following required content: - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with	0 680		

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0 680	Continued From page 19 local, tribal, regional, State and Federal EP to maintain integrated response; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may	0 680		

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0 680	Continued From page 20 choose to participate. On January 17, 2024, at 1:46 p.m., owner (O)-G stated a lot of their EPP templets were taken from the previous owner. O-G stated they were aware of the missing required contents, and they have another EPP templet, and they were working on getting it tailored to their facility's needs. The licensee's Emergency and Disaster Preparedness Policy & Procedure revised on June 30, 2023, read, "Golden Bay Homes will have this procedure in place to facilitate the management of resident's safety, care and services in response to natural disaster or other emergencies that may disrupt staff the ability to provide care and or services for residents." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970		

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0 970	Continued From page 21 contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of one resident (R1). 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's Assisting Living Contract was signed July 1, 2023. R1's Assisted Living Contract, page 4, titled Indemnification, read, "17. INDEMNIFICATION. Landlord shall not be liable for any damage to the Tenant's personal belongings of which reside in the Tenant's bedroom." On January 17, at 1:45 p.m., owner (O-G) stated they were not aware of the requirement to not include language waiving the facility's liability for health, safety, or personal property of a resident in the contract. The surveyor inquired if it applied to all contracts. O-G stated all resident contracts have the section listed above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01290	Continued From page 22	01290		
01290 SS=H	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for two of eight employees (unlicensed personnel (ULP)-C, ULP-F). 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 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:	01290		

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01290	Continued From page 23 ULP-C ULP-C was hired on January 19, 2021, to provide direct cares and services to residents. On January 16, 2024, the surveyor observed ULP-C providing cares to residents. The licensee's staff schedule for January 2024, indicated ULP-C was scheduled to work on the following days: -December 31, 2023, AM shift; -January 1, 12, 16, 19, 26, 2024, AM shift; and -February 2, 2024, AM shift. ULP-F ULP-F was hired on January 22, 2014, to provide direct cares and services to residents. The licensee's staff schedule for January 2024, indicated ULP-F was scheduled to work on the following days: -December 31, 2023, PM shift; -January 1, 8, 14, 15, 21, 22, 28, 29, 2024, PM shift. On January 16, 2024, at 1:18 p.m., owner (O)-G provided a current employee roster from NETStudy2.0 for BGS's. ULP-C and ULP-F both had "eligible covid 19 study" status' which had expired. ULP-C's BGS expired on June 26, 2021, and ULP-F's BGS expired on June 18, 2021. Both were run under the health facility identification number (HFID) 25528 which was affiliated with the licensee. On January 16, 2024, at 2:03 p.m., O-G stated they were aware of the BGS requirements with new employees but were not aware expired COVID 19 background studies needed to be	01290		

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01290	Continued From page 24 rerun. O-G stated it was their responsibility to manage and run BGS and did so through NETStudy2.0. On January 16, 2024, at 3:23 p.m., O-G stated they should have checked the BGS of the employees when they took ownership of the facility on July 1, 2023. The licensee's Background Studies Policy revised on September 9, 2023, indicated, "Golden Bay Homes will run a background study on all new employees with the Minnesota Department of Human Services using Netstudy 2.0. New employees will not be able to work alone until the study has been cleared. Copy of clearance letter will be kept in the employee file." The Minnesota Department of Human Services (DHS) website for Emergency Background Studies End dated as updated September 28, 2023, indicated, "Expiration dates for emergency studies are displayed as 12/31/2022 in NETStudy 2.0" and "The Background Studies Division no longer reviews new records or information for an individual who only has an emergency study in NETStudy 2.0." The DHS website for Background Studies dated as updated December 28, 2023, indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On January 17, 2024, the immediacy of	01290		

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01290	Continued From page 25 correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290		
01470 SS=F	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 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.	01470		

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01470	Continued From page 26 (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 completed required orientation before providing services for three of three supervising and direct care employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-E). 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).	01470		

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01470	Continued From page 27 The findings include: RN-A RN-A was hired on June 21, 2017, to provide direct cares to residents and oversite to ULPs. On January 16, 2024, at 12:55 p.m., the surveyor observed RN-E managing resident insulin pens. RN-A's employee record lacked training for the following required orientation topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. ULP-B ULP-B was hired on February 8, 2008, to provide direct cares to residents. On January 17, 2024, at approximately 8:30 a.m., the surveyor observed ULP-B administer medications for R1. ULP-B's employee record included a Relias (online training platform) transcript which lacked training for the following required orientation topics: -Overview of Assisted Living statutes; and -Assisted Living Bill of Rights.	01470		

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01470	Continued From page 28 ULP-E ULP-E was hired on December 2, 2023, to provide direct cares to residents. ULP-E's employee record included a Relias transcript which lacked training for the following required orientation topics: -Overview of Assisted Living statutes; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On January 17, 2024, at 12:04 p.m., ULP-B stated they were unsure if they had completed training for assisted living statutes or the assisted living bill of rights. On January 18, 2024, at 1:48 p.m., O-G stated they oversaw orientation for their staff and used Relias to make sure orientation topics were completed. O-G stated the missed orientation topics for RN-A and ULP-B were not completed. O-G stated they were familiar with newly hire staff orientation topics but was unsure of all required topics, "but I'm learning it now." O-G stated ULP-E had provided cares to residents but questioned whether ULP-E needed to have their orientation topics completed since they were not yet working on their own. The surveyor explained the staff orientation was required to be completed	01470		

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01470	Continued From page 29 before they provided services. On January 18, 2024, at 2:08 p.m., RN-A stated they had not completed all the required orientation topics. RN-A stated they asked ownership if they needed to complete any trainings, but nobody ever told them what was required to be completed. RN-A stated orientations would have been completed in Relias if they were done. RN-A stated the required orientation and trainings were assigned to them during survey and would complete them as soon as possible. The licensee's Staff Orientation and Training document dated June 14, 2023, indicated: "Orientation requirements - Orientation must be completed within 60 days of hire for direct support staff that combines supervised on-the-job training with review of and instruction in the following areas: Core Training to include but not limited to: -Safe medication assistance and administration -Observation, reporting and documenting resident care and status. -Basic elements of body functions, what to report -Appropriate and safe techniques in ADL's Safe and correct operation of medical equipment Vulnerable adult maltreatment reporting and internal review Program abuse and prevention plan New Employee forms to include: -Probationary Form -Job description & Personnel Policy -Minnesota Assisted Living Residents Bill of Rights -Drug and Alcohol Prohibition -Dept of Labor Employee Notice -Other policies: Back supports, Security Cameras, Disciplinary, PTO, Grievance, Conduct	01470		

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01470	Continued From page 30 with Residents -W4 & I9 CPR certification-required 2 Step TB -required TB Prevention Review Baseline TB Screening Tool For Health Care Workers Review of Assisted Living services, current Policies and Procedures and 144G Mn Statutes Alzheimers/Dementia Training Work Environment and Safety in the workplace Responding to emergencies and reporting incidents Grievance procedure/Handling resident's complaints and recording complaints Infection Control Universal precautions and sanitary practices HIPPA and data privacy Person-Centered Thinking Range of Motion, Fall Prevention, Body Mechanics COVID-19 Policies and Procedures Supervised on-the-job training Age related hearing loss Handling of Resident mail Rtasks" 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	01500		

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01500	Continued From page 31 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 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	01500		

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01500	Continued From page 32 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 observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in the required annual training topics for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: RN-A RN-A was hired on June 21, 2017, to provide direct cares to residents and oversite to ULPs. On January 16, 2024, at 12:55 p.m., the surveyor observed RN-E managing resident insulin pens.	01500		

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01500	Continued From page 33 RN-A's employee record lacked eight hours of annual training to include the following required topics: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; and -Principles of person-centered planning/service delivery. ULP-B ULP-B was hired on February 8, 2008, to provide direct cares to residents. On January 17, 2024, at approximately 8:30 a.m., the surveyor observed ULP-B administer medications for R1. ULP-B's employee record included a Relias (online training platform) transcript which lacked annual training for the following required topics: -Assisted Living Bill of Rights. On January 17, 2024, at 12:04 p.m., ULP-B stated they were unsure if they had completed all annual training topics. On January 18, 2024, at 1:48 p.m., O-G stated they oversaw training for their staff and used Relias to make sure annual training topics were completed. O-G stated they were familiar with the ongoing training requirements but was not sure which topics were to be covered or at the	01500		

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01500	Continued From page 34	01500		

frequency at which they should be completed, "but I'm learning it now." O-G stated annual trainings for RN-A and ULP-B were not completed.

On January 18, 2024, at 2:08 p.m., RN-A stated they had not completed annual training. RN-A stated they asked ownership if they needed to complete any trainings, but nobody ever told them what was required to be completed. RN-A stated training would have been completed in Relias if they were done. RN-A stated the required annual trainings were assigned to them during survey and would complete them as soon as possible.

The licensee's Annual Training Including Infection Control policy dated January 18, 2023, indicated: "POLICY: Staff will complete annual education to keep knowledge and skills current to provide quality care to residents.
PROCEDURE:
1. All assisted living employees will complete annual education on the following topics:
a. Reporting of maltreatment of vulnerable adults under section 626.557
b. Assisted living bill or rights
c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights
d. Infection control techniques used in the home and implementation of infection control standards including
i. Hand washing
ii. Need for and use of protective gloves, gowns, and masks
iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades
iv. Disinfecting reusable equipment
v. Disinfecting environmental surfaces

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01500	Continued From page 35 vi. Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training 2. Annual training will be documented in accordance with the documentation policy. 3. Direct-care staff will complete 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01530		

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01530	Continued From page 36 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 observation, interview, and record review, the licensee failed to provide employees with two hours of required annual dementia care training for one of two direct care employees (registered nurse (RN)-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 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: RN-A was hired on June 21, 2017, to provide direct cares to residents and oversite to ULPs. On January 16, 2024, at 12:55 p.m., the surveyor	01530		

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01530	Continued From page 37 observed RN-A managing resident insulin pens. RN-A's employee record lacked the required two hours of annual dementia training. The most recent dementia training found in RN-A's record was completed on April 11, 2018. On January 18, 2024, at 1:48 p.m., O-G stated they oversaw training for their staff and used Relias to make sure training topics were completed. O-G stated they were familiar with the ongoing training requirements for dementia but were unsure which topics were to be covered or the frequency at which it should be completed, "but I'm learning it now." O-G stated annual dementia training for RN-A was not completed. On January 18, 2024, at 2:08 p.m., RN-A stated they had not completed annual dementia training. RN-A stated they asked ownership if they needed to complete any trainings, but nobody ever told them what was required to be completed. RN-A stated training would have been completed in Relias if they were done. RN-A stated the required annual dementia training was assigned to them during survey and would complete them as soon as possible. The licensee's Staff Orientation and Training Policy, policy date updated to the date the file was opened as having been revised, indicated: "All current employees receive the following Annual training: -Infection Control -Alzheimers/Dementia -Minnesota Assisted Living Residents Bill of Rights -Drug and Alcohol -Person Centered Thinking -Age related hearing loss"	01530		

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01530	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 specific medication administration instructions for each resident was documented in the resident's record for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25528	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BAY HOMES	2700 62ND STREET EAST INVER GROVE HEIGHTS, MN 55076

(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
01750	Continued From page 39 The findings include: R1's Resident Contract and Service Plan dated July 1, 2023, indicated R1 received medication management services. R1's 90-day assessment completed on December 18, 2023, indicated R1 needed medication administration provided by staff, and staff stays with resident until medications are swallowed to prevent the diversion of medications by the resident or others who may have access to the medication. It also indicated R1 needed supervision with Trulicity injection. On January 17, 2024, at approximately 8:30 a.m., surveyor observed unlicensed personnel (ULP)-B set up R1's morning medication in a medicine cup. ULP-B brought the medicine cup along with Trulicity 1.5miligrams (mg)/2mililiters (ml) injectable to R1, put them on the dining table and went back to the kitchen to get apple sauce. ULP-B brought the apple sauce, put it on the dining table and left without watching R1 take the medication. R3 was sitting on the other side of the table and eating breakfast. R1 dumped all her medication into the apple sauce and took a couple pills at a time with spoon. R1 called ULP-B to administer the injection. ULP-B then came and attempted to administer the Trulicity without cleaning the injection site. The surveyor intervened as ULP-B was about to administer the injection without cleaning the injection site. The surveyor inquired if ULP-B had cleaned the injection site. ULP-B stated they usually do not clean the injection site because most of the time R1 self-administers Trulicity without cleaning the injection site. On January 17, 2023, at 9:00 a.m., surveyor	01750		

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01750	Continued From page 40 asked ULP-B if R1 was assessed for self-administration of medication (SAM). ULP-B stated R1 was able to self-administer their own medication after set-up, but they were not sure if there was a signed document. Owner (O)-G stated R1 can self-administer their medication and they thought they had a signed SAM assessment but was unable to find it. On January 17, 2023, at 2:08 p.m., registered nurse (RN)-A stated ULPs were not allowed to leave residents until they see them take their medications. RN-A stated R1 was not assessed to self-administer medications, and there was no signed SAM. The licensee's Medication administration policy undated, read, "-After identifying resident with the correct medication, explain purpose or name of medication to resident. Give medication with water or soft food/water. -Inspect mouth to ensure medication swallowed. Provide oral care if resident unable to swallow medication and notify RN." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=E	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	01890		

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01890	Continued From page 41 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with an opened-on date for two of three residents (R1, 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) 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: R1 R1's Clinical Update Assessment dated March 23, 2023, indicated R1 had a diagnosis of non-insulin dependent diabetes mellitus (NIDDM). R1's Resident Contract and Service Plan dated July 1, 2023, indicated R1 received medication management services. R1's record included a prescription dated January 3, 2024, which indicated R1 took the following medication: -Novolog, take 3 units (u) before breakfast and lunch, take 4u before dinner, take 2u before bedtime snack. On January 16, 2024, at 11:18 a.m., the surveyor observed R1's medication drawer with unlicensed personnel (ULP)-F. ULP-F stated whoever	01890		

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	25528	A. BUILDING: _____ B. WING _____	01/18/2024

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01890	Continued From page 42 opened a new insulin pen was responsible for labeling it with an opened-on date. ULP-F stated an insulin pen was okay to use until its manufacturer expiration date or once it was empty. ULP-F acknowledged the following insulin for R1 lacked an opened-on date: -Novolog FlexPen 100u/ml, 3ml prefilled insulin syringe pen; it had a yellow, "DATE OPENED," sticker which was left blank; it included a pharmacy tag for R1. R2 R2's Master Care Plan dated December 22, 2023, indicated R2 had a diagnosis of insulin-dependent diabetes mellitus (IDDM). R2's Resident Contract and Service Plan dated July 1, 2023, indicated R2 received services for medication administration and insulin injections. R2's record included a Bluestone Physician Services prescription dated January 5, 2024, which indicated R2 took the following medication: -Levemir 23u subcutaneously (SQ) at daily at bedtime. On January 16, 2024, at 11:31 a.m., the surveyor observed R2's medication drawer in the with owner (O)-G. O-G stated they did not know how long an insulin pen was okay to use after it was opened. O-G acknowledged the following insulin pen for R2 lacked an opened-on date: -Levemir FlexTouch insulin pen, 3ml prefilled syringe; it had a yellow, "DATE OPENED," sticker with an "H" written in the space for the date; it included a pharmacy tag for R2. On January 16, 2024, at 11:52 a.m., registered nurse (RN)-A stated all insulin pens required an opened-on date but did not know how long R1's	01890		

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	25528	A. BUILDING: _____ B. WING _____	01/18/2024

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01890	Continued From page 43 Novolog or R2's Levemir were able to be stored after they were opened and unrefrigerated. RN-A stated they required insulin pens to be marked with opened on dates, "but sometimes the marker markings rub off the label." RN-A stated the staff member who opened the insulin pen was responsible for labeling it with an opened-on date. The manufacturer's instructions for Novolog FlexPen 3ml prefilled pen revised February 2023 indicated it should be thrown away after 28 days of being opened or unrefrigerated, even if it still has insulin left in it. The manufacturer's instructions for Levemir FlexTouch 3 ml prefilled pens revised January 2019 indicated do not use past the expiration date or 42 days after you start using the pen. The licensee's Insulin Administration Policy indicated, "2. Date the OPEN Date of the insulin pen & EXPIRED Date 28 days from OPEN Date." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	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:	02310		

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02310	Continued From page 44 Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R1) with hospital bedrails. This resulted in an immediate correction order on January 17, 2024. 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: R1's diagnoses included diabetes, opioid dependence, orthostatic hypotension (blood pressure drops with a change in positioning), chronic diarrhea, peripheral neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet) and osteoarthritis. R1's Resident Service Agreement dated July 1, 2023, indicated R1 received services for bathing, dining, grooming, medication administration, toileting and transferring. R1's record included Side-Rail Use Assessment Form was completed on January 16, 2024, and backdated to March 9, 2023. On January 17, 2024, at 9:45 a.m., the surveyor observed R1's hospital bed which had bilateral half hospital bedrails in the lowered position. The	02310		

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02310	Continued From page 45 surveyor wiggled and pulled on both bedrails which were firmly attached to the bed. On January 17, 2024, at 10:18 a.m., registered nurse (RN)-A stated R1's bedrail was removed and put back on by a family member. RN-A stated the unlicensed personnel (ULP) were educated multiple times to report bedrail use, but none of the ULP reported R1 had bedrails on their bed. RN-A stated no bedrail assessment was done since March 9, 2023. On January 17, 2024, at 10:38 a.m., the surveyor inquired for the timeline when R1 was admitted, when the bedrail was put on, when the family removed it, and when it was put back on. RN-A stated R1 was admitted on March 9, 2023, with no bedrails. RN-A stated they completed R1's 14-day assessment on March 23, 2023, in person and there were no bedrails. RN-A then stated the bedrail assessment dated March 9, 2023, was completed yesterday, January 16, 2024, and it was backdated to March 9, 2023. RN-A stated there were no bedrail assessments completed until January 16, 2024. On January 17, 2024, at 10:48 a.m., ULP-B stated R1 had the bedrail since she arrived at the facility. ULP-B stated she was not educated to report bedrail use to the RN. On January 17, 2024, at 10:51 a.m., R1 stated they had the bedrails for several years and they had it since their admission. R1 stated they signed the Side-Rail Use Assessment Form yesterday, January 16, 2024. The surveyor inquired if R1 knew the form was backdated to March 9, 2023. R1 stated RN-A told them the form was backdated because R1 had the bedrail since admission, but it had not been caught until	02310		

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02310	Continued From page 46 yesterday. The form had the date filled in by the RN. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's Hospital Bed Side Rails Policy last reviewed and revised on January 17, 2024, read: " POLICY: When [licensee] is aware a resident is utilizing side rails on a hospital bed, [licensee name] will assess the use, educate the resident or resident's representative, regarding the risks and benefits of side rails. [Licensee] will verify	02310		

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02310	Continued From page 47 that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail.." No further information provided. TIME PERIOD FOR CORRECTION: Immediate On January 18, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	02310		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during	02410		

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02410	Continued From page 48 toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support reasonable privacy during activities for toileting and bathing for all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was a two-level rambler style home with a main floor and a basement. There was a bathroom on the main level just off the kitchen and a second bathroom in the basement at the bottom of the stairs. On January 16, 2024, at 10:59 a.m., during the facility tour, the surveyor observed the basement level bathroom which had two doors on two separate walls of the bathroom, both doors lacked a locking mechanism. The surveyor observed the main level bathroom which had one door and lacked a locking mechanism. Owner (O)-G stated neither bathroom door had a locking mechanism. O-G stated they had issues with one of their residents putting toilet paper and paper towels in the toilet which caused plumbing problems. O-G stated if a problem were to occur,	02410		

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02410	Continued From page 49 they didn't want a resident to be able to lock themselves in the bathroom and then be unable to unlock the door to get them out. On January 17, 2024, at 12:04 p.m., R1 stated it made them uncomfortable the bathroom doors did not lock. On January 18, 2024, at 1:48 p.m., O-G acknowledged the bathroom doors without locking mechanisms created a privacy concern and would need to figure out a solution. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/17/24*
Time: 16:47:52
Report: 1036241009

Food and Beverage Establishment Inspection Report

Location:

Golden Bay Homes
2700 62nd Street E
Inver Grove Heights, MN55075
Dakota County, 19

Establishment Info:

ID #: 0042324
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 6127033254
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: > at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 2 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: BASEMENT FRIDGE
Violation Issued: No

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

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JOEY KEEN. INSPECTION CONDUCTED IN PRESENCE OF XUAN TRAM NGUYEN, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

Food and Beverage Establishment Inspection Report

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER
- PEST MANAGEMENT

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

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

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

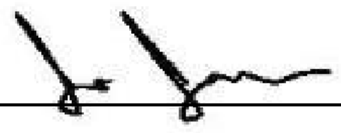
I acknowledge receipt of the inspection report number 1036241009 of 01/17/24.

Certified Food Protection Manager KELLEN R. JACOBSON

Certification Number: FM20019 Expires: 11/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
XUAN TRAM NGUYEN
OPERATOR

Signed: 
Jeff Johanson