Electronically Delivered

September 24, 2024

Licensee
Goldenview Healthcare Services
1001 65th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36541015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 22, 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.

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

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

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

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

The correction order documentation should include the following:

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

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

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

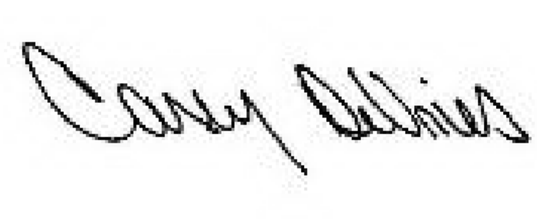
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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
	36541	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENVIEW HEALTHCARE SERVICES	1001 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

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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: SL36541015-0 On August 19, 2024, through, August 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four resident(s); all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 August 19, 2024, at 9:55 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director stated, ""We do not have a need for call lights they have their cell phones they are responsible for, and they have the house phone, or they can just yell for us." On August 19, 2024, at 1:00 p.m., during a facility tour, the surveyor observed a rambler style home with a basement with two of the resident rooms located on the main level and two of the resident rooms located on the lower level. In addition, the surveyor observed no bells, call lights, or pendants provided for the residents to summon assistance. On August 20, 2024, at 12:41 p.m., unlicensed personnel (ULP)-B stated, "If [residents] need to get ahold of us, they will yell or use their cell phones." Ths surveyor inquired if R3 had a cell phone and ULP-B stated, "No she doesn't, sometimes the residents will have a cell phone like [R2] did, and they will lose it and then they don't have one. That is what [R3] did. But they could always take the house phone to their room if it is charged and use that, they are allowed to use the house phone." When asked where the house phones are charged at ULP-B stated, "We have one here (by the TV in the common area) and one downstairs." When asked what they would do if they didn't have a cell phone or house phone and they needed help ULP-B stated, "They would just yell for one of us." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 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 August 20, 2024, for the specific Minnesota Food Code deficiencies. The inspection report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 4 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the licensee's 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: During a facility tour of the main floor on August 19, 2024, at 11:12 a.m., the surveyor observed	0 550		

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0 550	Continued From page 5 the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On August 19, 2024, at 12:03 p.m., licensed assisted living director (LALD)-C acknowledged the required content was not posted in the common areas. LALD-C stated, "The staff can print it out and there is a copy of it in each resident binder, but it isn't posted anywhere, and if that is the case that it needs to be, I will need to post it, because they will need to get staff to help them get the form." The licensee's Grievance policy, dated November 1, 2023, read, "A copy of the grievance procedure is conspicuously posted in the residence with the following information: - Name, phone number and email contact information for the individuals who are responsible for handling resident complaints - Contact information for the state and any regional Office of Ombudsman for Long-Term-Care - Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities - Contact information for the Minnesota Adult Abuse Reporting Center." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 640	Continued From page 6	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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: On August 19, 2024, at 11:12 a.m., the surveyor observed no 911 emergency number posted near	0 640		

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0 640	Continued From page 7 the community telephone in the living room. On August 19, 2024, at 11:58 a.m., licensed assisted living director (LALD)-C acknowledged the phone in the living room was used by residents and staff and the posting for 911 was not visible from the phone, and stated, "I will get it posted by the phones this evening." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 680		

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0 680	Continued From page 8 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 lacked evidence of the following required content: -address the following whether evacuated or shelter in place for staff/residents; -food, water, medical supplies, pharmaceutical supplies; -alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal.	0 680		

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0 680	Continued From page 9 -develop policies and procedures (P/P) that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On August 20, 2024, at 7:46 a.m., house manager (HM)-A acknowledged the licensee was missing the above-mentioned items and stated, "If it's not in the binder, then we do not have it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to	0 700		

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0 700	Continued From page 10 control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four resident's (R2) personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: On August 20, 2024, from 11:56 a.m. to 11:59 a.m., the surveyor observed unlicensed personnel (ULP)-B leave the table in the dining room where the facility tablet with the licensee's electronic charting system used for accessing resident records for medications and treatments was left open and displayed R2's personal health and medical information. The screen displayed all of the resident's identifying information and medications. ULP-B went to another floor in the facility to gather supplies and did not return to the unlocked tablet until 11:59 a.m. During this time, the surveyor observed three residents in the facility moving throughout the commons area. On August 20, 2024, from 12:37 p.m., to 12:40	0 700		

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0 700	Continued From page 11 p.m., the surveyor observed ULP-B leave the table in the dining room where the facility tablet was left open and displayed R2's personal health and medical information. The screen displayed all of R2's identifying information and medications. ULP-B went to another floor in the facility and did not return to the unlocked tablet until 12:40 p.m. During this time, the surveyor observed three residents in the facility moving throughout the commons area. On August 20, 2024, at 12:43 p.m., ULP-B stated, "We should make sure there is no resident info showing on the screen when we walk away, I try not to forget that." On August 21, 2024, at 10:12 a.m., clinical nurse supervisor (CNS)-D stated resident records should only be accessible to those authorized to view the information. The licensee's Privacy of Protected Health Information policy dated November 1, 2023, read, "Staff will maintain confidentiality of protected health information in the office and when doing business on behalf of [licensee]. - No clinical records or personal health information about residents will be accessible in public areas of the office. - A cover sheet will always be used when faxing information about residents. The resident's name will not appear on the cover sheet. - When emailing information about residents, the resident's name will never appear in the subject line. Care will be taken to avoid using names in emails. - Protected health information will not be discussed on cell phones in public areas. - When possible, staff will avoid leaving messages with protected health information on	0 700		

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GOLDENVIEW HEALTHCARE SERVICES	1001 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 700	Continued From page 12 voice mail. - Papers containing protected health information will be shredded." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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 monthly maintenance on fire extinguishers as required. This had the potential to affect all current 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	0 790		

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0 790	Continued From page 13 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 August 21, 2024, at 11:00 a.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, it was observed the portable fire extinguishers were tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. On August 21, 2024, at 11:30 a.m., HM-A verified required monthly inspection had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a	0 800		

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0 800	Continued From page 14 continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 21, 2024, at 11:00 a.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following items: In resident room 3 on the main level, it was observed the closet door was broken and detached from the rail. In the bathroom on the main level, it was observed the following items: -It was observed the wall and wall base had considerable brown stains. -It was observed the light fixture over the vanity was missing light bulbs. -It was observed that the ceiling plaster was bubbled with evidence of water damage. -It was observed that the shower facet was broken, and water leaked from it. In the kitchen on the main level, it was observed the wall next to the refrigerator was badly damaged. The wall pilaster was chipped badly, and paint was bubbled.	0 800		

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0 800	Continued From page 15 In the wood deck outside the kitchen, it was observed that the wood guard rail pickets were broken. On the patio outside the exit door to the backyard, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. In the garage, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. It was also observed there were many burn marks on the fabric couch from the inappropriate cigarette disposal. It was observed that the exterior soffit and soffit facia were damaged badly, and the paint was bubbled with evidence of water damage. HM-A stated the damage was caused by an ice dam last winter. In the bathroom on the lower level, it was observed the following items: -It was observed the floor tiles near the shower tub was badly damaged and had considerable brown stains with evidence of eater damage. -It was observed the wall and wall base had considerable brown stains from water damage. In the laundry room on the lower level, it was observed the vinyl floor tiles were ripped and lifted, creating a tripping hazard for residents. During the facility tour at 11:00 a.m., HM-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 16 days	0 800		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 19, 2024, at 11:05 a.m., licensed assisted living director (LALD)-C provided the surveyor with a blank Assisted Living Contract, and stated the same contract was utilized for all residents.	0 970		

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0 970	Continued From page 17 The licensee's Assisted Living Contract included the following sections that indicated a waiver of liability: "Miscellaneous Provisions: Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents. Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced."	0 970		

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0 970	Continued From page 18 On August 19, 2024, at 11:58 a.m., LALD-C indicated he was unaware a waiver of liability was still in the contract and stated, "We will change contract today." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	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; (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.	01060		

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01060	Continued From page 19 (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 the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3). 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: R3 was admitted to the licensee and began	01060		

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01060	Continued From page 20 receiving assisted living services on November 19, 2023. R3's Progress note, dated July 18, 2024, indicated R3 had been hospitalized. R3's Progress note, dated July 22, 2024, indicated R3 was still hospitalized. R3's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On August 21, 2024, at 11:57 a.m., the surveyor received and email from the licensed assisted living director (LALD)-C that read, "I do not have emergency relocation forms that were sent to the ombudsman. I have not sent any emergency relocation forms to the ombudsman. Sorry, however I was not aware that emergency relocation forms had to be sent to the ombudsman when a client goes to the hospital." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 21 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure ongoing resident reassessments did not exceed 90 days for two of two residents (R1, R3) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 R1 was admitted to the licensee and began receiving services on November 19, 2023.	01620		

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01620	Continued From page 22 R1's diagnoses included anxiety disorder, depression, personality disorder and type 2 diabetes. R1's Service Plan form dated February 2, 2024, indicated R1 received assistance with medication administration, housekeeping, meal preparation, shopping, and safety checks. On August 20, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. R1's 14-day and ongoing 90-day reassessments titled [Licensee] Nurse Reassessment visit, dated January 22, 2024, April 22, 2024, and July 22, 2024, indicated 92 days had passed between each of the assessments. R3 R3 was admitted to the licensee and began receiving assisted living services on November 19, 2023. R3's diagnoses included asthma, developmental disorder, and schizoaffective disorder. R3's Service Plan form dated February 2, 2024, indicated R3 received assistance with dressing, grooming, bathing, meal preparation, medication administration, monthly vital signs, safety checks, and housekeeping. R3's ongoing 90-day reassessments titled [Licensee] Nurse Reassessment visit, dated April 22, 2024, July 22, 2024, and August 16, 2024 were not completed. All included a note to indicate the resident was not available when the nurse was available to do the reassessment and	01620		

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01620	Continued From page 23 indicated that 214 days had passed since the last assessment completed. On August 21, 2024, at 10:22 a.m., clinical nurse supervisor (CNS)-D stated, "When we do the 90-day assessment I try to do all the clients in the house on the same day unless there is change of condition otherwise, we try to stick to that routine of the same date, like the 15th of the month every three months or whatever the date it is." The licensee's Assessment and Reassessment policy, dated November 1, 2023, read, "The RN will provide the admission visit, conduct and document** a comprehensive assessment*** and prepare a care plan based on the comprehensive evaluation. If services are provided to a resident before the assessment, the RN will complete a temporary plan with the resident and orient staff to services as identified in the temporary plan. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from 12:38 p.m., through 12:51 p.m., the surveyor observed the medication cabinet that stored R3's medications to be slightly ajar and unlocked. On August 20, 2024, at 12:51 p.m., unlicensed personnel (ULP)-B stated, "We unlock the med cabinet in the morning, and we leave them unlocked until after the morning meds are taken and the reason that [R3's] med cabinets are unlocked is because she has not yet taken her meds, but I will lock it now because it's too late to give those meds now. The others are locked you see because they took their meds this morning." On August 21, 2024, from 9:45 a.m., through 10:30 a.m., the surveyor observed the medication cabinets that stored all resident's medications to be unlocked, and unattended as ULP-B worked throughout the facility. At 10:30 a.m., the surveyor showed house manager (HM)-A that the	01880		

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01880	Continued From page 25 medication cabinet was left unlocked and unattended. HM-A went to find ULP-B to obtain the keys to lock the cabinet. On August 21, 2024, at 10:27 a.m., clinical nurse supervisor (CNS)-D stated all medications were to be kept locked in the medication cabinets. The licensee's Storage/Control of Medications policy, dated November 1, 2023, read, "When [Licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Follow-Up
Date: *09/03/24*
Time: 13:07:30
Report: 7963241102

Food and Beverage Establishment Inspection Report

Location:
Goldenview Healthcare
1001 65th Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0037528
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
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

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER RINSE TEMP
Violation Issued: No

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

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 7963241102 of 09/03/24.

Certified Food Protection Manager: Messiah Moore

Certification Number: fm 114869 Expires: 12/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Messiah Moore

Signed: Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *08/20/24*
Time: 15:45:54
Report: 7963241091

Food and Beverage Establishment Inspection Report

Location:
Goldenview Healthcare
1001 65th Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0037528
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER RINSE ONLY REACHED 139 DEG F DURING CYCLE. REPAIR/ADJUST DISHWASHER SO IT REACHES 160 DEG F SURFACE TEMPERATURE.

Comply By: 08/20/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETER AVAILABLE TO TAKE COOKING TEMPERATURES WHEN COOKING RAW MEATS. PROVIDE AND USE.

Comply By: 08/21/24

Surface and Equipment Sanitizers

Hot Water: = at 139 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: Yes

Food and Equipment Temperatures

Type: Full
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Food and Beverage Establishment Inspection Report

Process/Item: MILK
Temperature: 34 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

MET WITH MDH SURVEYOR TESA BROWN AND ESTABLISHMENT REPRESENTATIVE WACHEN JOSIAH AND MESSIAH MOORE.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-HAND WASHING
-COLD HOLDING TEMPERATURES
-SAME DAY SERVICE REQUIREMENTS
-VOMIT/FECAL CLEAN-UP POLICY

ESTABLISHMENT HAS A DISHWASHER.

PHYSICAL FACILITIES- WOOD FLOORING, PAINTED CABINETS, SOLID SURFACE COUNTERTOP AND SMOOTH PAINTED CEILING.

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 7963241091 of 08/20/24.

Certified Food Protection Manager: Messaih Moore

Certification Number: FM 114869 Expires: 12/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Messiah Moore

Signed: _____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241091

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	1	**Date**	08/20/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	15:45:54
Legal Authority MN Rules Chapter 4626		**Time Out**	

Goldenview Healthcare	**Address** 1001 65th Avenue North	**City/State** Brooklyn Center, MN	**Zip Code** 55430	**Telephone** 9526586176
License/Permit # 0037528	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	(IN)	OUT	N/A	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/21/24

Inspector (Signature) Peggy Spudy