



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 6, 2025

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

RE: Project Number(s) SL30395016

Dear Licensee:

On October 24, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessie Chenze'.

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 8, 2025

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

RE: Project Number(s) SL30395016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 518 7TH AVENUE NE AITKIN, MN 56431			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30395016 On July 21, 2025, through July 23, 2025, 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 41 residents receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on July 22, 2025, for tag identification 2310, issued at a level three, isolated scope (G). The licensee took mitigating action, however the correction order remains at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 510 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 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 ensure infection control standards were followed by two of four employees (unlicensed personnel (ULP)-I, ULP-H) while providing assistance to four of eight residents (R5, R4, R11, R16). 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:	0 510			

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0 510	Continued From page 4 ULP-I ULP-I was hired on February 10, 2025, to provide direct care services to the facility's residents. ULP-I's employee record included infection control dated February 23, 2025, and June 27, 2025, respectively. On July 22, 2025, from 6:19 a.m. through 6:39 a.m., the surveyor continuously observed ULP-I. On July 22, 2025, at 6:19 a.m., the surveyor observed ULP-I apply gloves, gather supplies (blood glucose meter [device that will test blood sample to determine blood glucose level], testing strip, lancet pen [device with a small removable needle, attached to a pen type of device, used to poke the skin -usually on a finger] and alcohol pad). ULP-I massaged R5's pointer finger of R5's left hand. ULP-I cleaned R5's left pointer finger with an alcohol wipe. ULP-I used the lancet pen. ULP-I placed the drop of blood onto the test strip to obtain a reading of 112. ULP-I wiped R5's left pointer finger with the alcohol wipe. On July 22, 2025, at 6:22 a.m., ULP-I removed gloves, and documented in R5's record. ULP-I unlocked the medication cart. ULP-I removed the needle for the lancet devise (without gloves, while she stated she (ULP-I did not like those needles). ULP-I returned the blood glucose supplies to the cart. The surveyor did not observe ULP-I perform hand hygiene. On July 22, 2025, at 6:25 a.m., ULP-I applied gloves, gathered supplies and went to R4's room. ULP-I cleaned the pointer finger on R4's right had with an alcohol pad, used a lancet (single use/disposable type), to obtain a reading of 113.	0 510			

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0 510	Continued From page 5 On July 22, 2023, at 6:26 a.m., ULP-I returned to the medication cart, disposed of the lancet in a Sharps container. ULP-I removed gloves and returned the blood glucose testing supplies to the medication cart. The surveyor did not observe ULP-I perform hand hygiene. On July 22, 2025, at 6:32 a.m., ULP-I stepped outside into the attached resident's courtyard/outside area and smoked a cigarette. On July 22, 2025, at 6:39 a.m. ULP-I entered the building and went to the sink and washed her hands. On July 22, 2025, at 6:53 a.m., ULP-I stated she changed gloves. ULP-I stated she did not wash her hands and does not wash hands in-between glove use. ULP-H ULP-H was hired on February 14, 2023, to provide direct care services to the facility's residents. On July 22, 2025, at 7:15 a.m., the surveyor observed ULP-H with gloves on, place an SpO2 monitor (non-invasive devise to measure oxygen level in blood) on R11's finger to obtain a reading of 94%. R11 told ULP-H his blood glucose was 184. ULP-H prepared R11's Novolog insulin pen (short acting insulin) and handed the pen to R11. R11 self-administered insulin into his abdomen. R11 handed the insulin pen back to ULP-H. ULP-H removed gloves worn. The surveyor did not observe ULP-H perform hand hygiene. On July 22, 2025, at 7:20 a.m., the surveyor observed ULP-H enter R16's room. ULP-H	0 510			

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0 510	Continued From page 6 applied gloves. ULP-H assisted R16 onto the toilet. ULP-H removed gloves. On July 22, 2025, at 7:22 a.m., ULP-H stated she forgot to wash hands between glove changes. On July 22, 2025, at 9:43 a.m., CNS-C stated ULPs should perform hand hygiene in-between glove changes. The licensee's Standard Precautions policy dated March 18, 2020, noted standard precautions applied to exposure to 1) blood, 2) all body fluids, secretions, and excretions, except sweat, regardless of whether or not they contained visible blood 3) non-intact skin 4) mucous membranes. Standard precautions included the use of hand washing, appropriate personal protective equipment such as gloves, gowns, masks, whenever touching or exposure to patient's body fluids was anticipated. Hands should be washed after removing gloves and after any direct contact with body secretions. The licensee's Hand Washing policy dated March 18, 2020, noted when conducting a procedure required the use of gloves, proper hand washing shall be completed before applying gloves and after removing gloves. The licensee's Gloves policy dated March 18, 2020, noted gloves are to be worn whenever completing care related tasks, medication management or there may be direct contact between any employee and contaminated or sterile objects: 1) wash hands 2) apply gloves to both hands 3) complete assigned task/removed contaminated materials	0 510			

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0 510	Continued From page 7 4) plane materials in proper receptacle if applicable 5) remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. dispose of in proper receptacle 6) rewashed hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) with the required content was developed for one of three individuals residing in the assisted living facility (R8).	0 630			

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0 630	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 was admitted to the facility on May 12, 2025. R8's diagnoses included heart failure, anemia, chronic inflammatory lung disease (COPD/ causes obstructed airflow from the lungs) and dependence on supplemental oxygen. R8's service plan dated July 8, 2025, indicated R8 received the following services: - medication administration - oxygen management - safety checks - monthly vital sign monitoring - housekeeping services. On July 22, 2025, at 7:34 a.m., the surveyor observed unlicensed personnel (ULP)-H hand R8 a medication cup that contained R8's morning oral medication. ULP-H handed R8 a Flonase bottle (nasal medication/allergies) and R8 self-administered the nasal medication. ULP-H handed R8 a Trelegy inhaler (COPD). R8 placed the inhaler up to her (R8's) lips and inhaled. R8's abuse prevention plan dated June 11, 2025, noted: resident is susceptible to abuse by other residents, if yes, specify measures to minimize	0 630			

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0 630	Continued From page 9 risk in note: - yes, resident is susceptible to abuse due to her age and functional status resident is at risk to be abused (physically, verbally, emotionally, financially, and/or sexually), specify measures to minimize risk: - yes, related to age and functional status is resident at risk for abuse by another individual, including other vulnerable adults or minors? - yes, resident is always at risk for abuse due to age and health status. R8's abuse prevention plan did not include specific measures to be taken to minimize the risk of abuse. On July 22, 2025, at 1:42 p.m., R8's abuse assessment was reviewed with operations director/registered nurse (OD/RN)-D. OD/RN-D stated she "saw" R8's assessment lacked specific interventions. Clinical nurse supervisor (CNS)-C stated she was not sure why R8's abuse prevention plan lacked specific measure. CNS-C stated it was "strange" R8's abuse assessment lacked required information. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to be free from physical, sexual, and emotional abuse: neglect; financial exploitation; and all form of maltreatment covered under the Vulnerable Adults Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

Minnesota Department of Health

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0 640	Continued From page 10	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 and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number in common areas and by telephones for resident use in the facility. This had the potential to affect 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 July 21, 2025, at 10:10 a.m., during the entrance conference with licensed assisted living	0 640			

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0 640	Continued From page 11 director (LALD)-A and clinical nurse supervisor (CNS)-C the surveyor was told there were 41 residents in total who resided at the assisted living facility: 26 residents in the non-secured unit, 15 residents in the secured unit. On July 21, 2025, at 10:45 a.m., during a tour of the facility with LALD-A, the surveyor did not observe the 911 emergency number in common areas and near telephones provided by the assisted living facility in the non-secured unit. On July 21, 2025, at 10:49 a.m., the surveyor questioned LALD-A if the posting of 911 emergency number had been missed? LALD-A stated the 911 emergency number was not posted in the common's area or near phones in the non-secured unit. LALD-A stated the 911 emergency number was not posted as required in the secured unit. On July 21, 2025, at 11:00 a.m., the surveyor observed a coded door, to enter the secured unit attached to the non-secured unit. The surveyor did not observe the 911 emergency number in the secured unit. LALD-A stated she was not sure if she was aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The	0 650			

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0 650	Continued From page 12 records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained required content for two of two employees (unlicensed personnel (ULP)-J, ULP-G). 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:	0 650			

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0 650	Continued From page 13 R12's diagnoses included Alzheimer's with behavioral disturbance, anxiety, frail elderly, muscle weakness, sleep disorder, generalized weakness, and age-related osteoporosis without current pathological fracture (reduced bone mass, decrease in thickness resulting in increased fracture incidence.) R12's service plan dated January 29, 2025, indicated R12 received the following services: - position/re-positioning. R12's comprehensive nursing assessment dated June 16, 2025, included: - mobility-wheelchair needs assistance with wheelchair at all times for mobility: staff to provide escort to all meals and activities. Resident unable to wheel self. Staff are needed to help maneuver resident in wheelchair - manual wheelchair Broda [a wheelchair offering tilt-n-space positioning [allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure] with a seating system which prevents skin breakdown through reducing heat and moisture). On July 22, 2025, at 9:56 a.m., the surveyor observed ULP-G and ULP-J assist R12 into a Broda wheelchair. ULP-G adjusted the chair tilt. ULP-J ULP-J was hired on February 24, 2025, to provide direct care services to the facility's residents. ULP-J's record did not include training and competency for Broda wheelchair. ULP-G	0 650			

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0 650	Continued From page 14 ULP-G was hired on March 25, 2025, to provide direct care services to the facility's residents. ULP-G's record did not include training and competency for Broda wheelchair. On July 23, 2025, at 12:11 p.m., operations director/registered nurse (OD/RN)-D stated, "to be honest with you (surveyor) I don't think we have any training on Broda wheelchairs." On July 23, 2025, at 12:46 p.m., clinical nurse supervisor (CNS)-C stated she did train and deem ULPs competent on Broda wheelchairs. CNS-C listed off several names (ULPs) she recently trained and deemed competent on Broda wheelchairs. CNS-C stated she completed training and competency for Broda but stated "maybe" we (licensee) don't have anything in the ULPs employee records. The surveyor asked CNS-C if Broda training was found in ULP records to get it to the surveyor by noon the following day. The surveyor did not receive records of Broda training. The licensee's Training and Competency Evaluation for Unlicensed Personnel policy dated March 18, 2020, noted a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's Employee Records policy dated March 18, 2020, noted records must include records of orientation, required annual training and infection control training, and competency evaluations. In addition, training records would include: - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to one	0 650			

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0 650	Continued From page 15 training, the date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluation, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competence evaluation - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation - documentation of the completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training was completed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a	0 650			

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0 650	Continued From page 16 statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 775			

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0 775	Continued From page 17 On facility tour with director of maintenance (DM)-E and licensed assisted living director (LALD)-A on July 22, 2025, between 12:00 p.m. and 3:30 p.m. the following deficient conditions were observed: LOCKING: The surveyor observed there was a green button in the nurse's office in the dementia care wing that released only the inside door to the assisted living wing. There shall be a key/switch/button that unlocks all required exit doors in the dementia care wing. The gate lock shall have the same locking/unlocking capability as the exit doors from the facility unless the exit door to the courtyard is deemed as not a required exit by a design professional or licensed architect. FIRE/SMOKE DOORS: The surveyor observed the doors from the resident rooms to the corridor and other doors (Kitchen/Mechanical) did not close and latch under their own power. A few doors have their closures removed and several were being held open by different means. A review of the architectural plans verified that these doors were designed to close and latch and were installed that way during construction. These doors shall close and latch under their own power. ELECTRICAL:	0 775			

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0 775	Continued From page 18 The surveyor observed open electrical wires near the ceiling in the shower room on the dementia care side of the facility. The wires shall be properly capped and installed in an approved electrical junction box with a cover. The deficient conditions were visually verified by the DM-E and LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written	01420			

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01420	Continued From page 19 instructions in the resident's record for delegated tasks provided by unlicensed personnel (ULP) for one of three residents (R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's diagnoses included Alzheimer's with behavioral disturbance, anxiety, frail elderly, muscle weakness, sleep disorder, generalized weakness, and age-related osteoporosis without current pathological fracture (reduced bone mass, decrease in thickness resulting in increased fracture incidence). R12's service plan dated January 29, 2025, indicated R12 received the following services: - dressing/ grooming - transfer assistance of two - behavior: anxiety/aggression -toileting - special diet - safety checks - position/re-positioning. R12's comprehensive nursing assessment dated June 16, 2025, included: - mobility-wheelchair needs assistance with wheelchair at all times for mobility: staff to provide escort to all meals and activities. Resident unable to wheel self. Staff are needed to help maneuver	01420			

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01420	Continued From page 20 resident in wheelchair - manual wheelchair Broda [a wheelchair offering tilt-n-space positioning [allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure] with a seating system which prevents skin breakdown through reducing heat and moisture). On July 22, 2025, at 9:56 a.m., the surveyor observed ULP-G and ULP-J assist R12 into a Broda wheelchair. ULP-G adjusted the chair tilt. The surveyor asked ULP-G if there were directions in R12's record for Broda use. ULP-G pointed to two stickers on the back of R12's Broda wheelchair: - green torn and worn sticker on lower rail, by foot pedals, applied by manufacturer. The sticker noted the number one, and included a drawing of an arrow than noted a person (stick drawing) to indicate the chair's position could be changed - white torn and worn sticker on upper rail/hand levers, place near the middle of chair, applied by manufacturer. The sticker noted the number two, and noted "recline". The sticker included a stick drawing of a head/body and an arrow to indicate the head of the chair could be tilted back/ head lowered. R12's record lacked instructions for R12's Broda wheelchair. On July 23, 2025, at 11:56 a.m., clinical nurse supervisor (CNS)-C stated she reviewed R12's record and she (CNS-C) was "owning it" (lack of instruction in R12's record for Broda wheelchair). CNS-C stated R12's record had not included specific instructions for R12's Broda wheelchair. CNS-C handed the surveyor an updated position/ re-position assignment sheet dated July 22, 2025,	01420			

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01420	Continued From page 21 (completed the day prior), that noted: resident to reposition with reminders to offset pressure. If resident appears sleepy or if wheelchair in motion, please recline the resident. If resident is eating or awake, please ensure the resident is in an upright position. The licensee's Training and Competency Evaluation for Unlicensed Personnel policy dated March 18, 2020, noted when appropriately specific to the client (resident), the registered nurse or licensed health professional must document instructions for the delegated tasks in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640			

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01640	Continued From page 22 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for one of three residents (R12). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's diagnoses included Alzheimer's with behavioral disturbance, anxiety, frail elderly, muscle weakness, sleep disorder, generalized weakness, and age-related osteoporosis without current pathological fracture (reduced bone mass, decrease in thickness resulting in increased fracture incidence.) R12's service plan dated January 29, 2025, indicated R12 received the following services: - dressing/ grooming - transfer assistance of two - behavior- anxiety/aggression - toileting	01640			

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01640	Continued From page 23 - special diet - safety checks - position/re-positioning. R12's comprehensive nursing assessment dated June 16, 2025, included: - mobility-wheelchair needs assistance with wheelchair at all times for mobility: staff to provide escort to all meals and activities. Resident unable to wheel self. Staff are needed to help maneuver resident in wheelchair - manual wheelchair Broda [a wheelchair offering tilt-n-space positioning [allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure] with a seating system which prevents skin breakdown through reducing heat and moisture). On July 22, 2025, at 9:56 a.m., the surveyor observed unlicensed personnel (ULP)-G and ULP-J assist R12 into a Broda wheelchair. ULP-G adjusted the chair tilt. R12's service plan was not revised as required, to include escorts. On July 23, 2025, at 11:54 a.m., R12's service plan was reviewed with operations director/registered nurse (OD/RN)-D. OD/RN-D stated R12's service plan had been revised to include escorts, as R12's Broda wheelchair did not allow for any self-propelling and R12 was dependent on ULPs for location/escort needs. The licensee's Service Plan Modification policy dated March 1, 2020, noted if the service plan or agreement must be modified due to a change in a prescriber's order or a change in the clients' (residents) needs, a new service plan would be	01640			

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01640	Continued From page 24 signed by the resident or resident's representative and a facility representative: - describe changes in service - frequency of new service or of old service if terminated - who is to perform the service - frequency of supervision - charge for the service - date/signature of RN (registered nurse making changes) - date/signature of client or the client's representative each time a modification was made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01750 SS=F	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:	01750			

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01750	Continued From page 25 Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for three of three residents (R5, R11, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R5 R5's diagnoses included diabetes, cognitive impairment, obesity, dementia, and mood disorder. R5's service plan dated September 30, 2024, indicated R5 received medication administration four times daily, and monthly. R5's medication administration record (MAR) dated July 1, 2025, through July 22, 2025, included: Ozempic (diabetes/weight loss) two milligrams/dose (eight mg/three milliliters) (ml) Tuesday - pen is blue with gray pusher. Inject 0.75 ml (two mg) subcutaneously (SQ) once weekly. R5's prescriber's order dated April 30, 2025, included the above order. On July 22, 2025, at 6:19 a.m., the surveyor	01750			

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01750	Continued From page 26 observed unlicensed personnel (ULP)-I monitor R5's blood glucose to obtain a reading of 112. On July 22, 2025, at 2:04 p.m., the surveyor reviewed R5's record (MAR) with operations director/registered nurse (OD/RN)-D. OD/RN-D stated R5's record lacked inclusion of injection site for Ozempic as required. The manufacturer's instructions for Ozempic dated September 2023, noted inject Ozempic SQ to the abdomen, thigh, or upper arm. Use a different injection site each week when injecting in the same body region. When using Ozempic with insulin, administer as separate injections and to never mix the products. It is acceptable to inject Ozempic and insulin in the same body region, but the injections should not be adjacent to each other. R11 R11's diagnoses included diabetes. R11's service plan dated May 14, 2025, indicated R11 received medication administration five times daily, and every ten days. R11's MAR dated July 1, 2025, through July 22, 2025, included: Novolog pen (100 units/ml, short acting insulin) is blue with orange pusher. Use a new needle for each injection. Prime the pen before every dose is given by dialing the pen to two units, point the pen up, and press the plunger button down until the two units comes out. Then dial up the number of units ordered and administer. Unopened pens are stored in refrigerator. Use date open sticker. Expires 28 days after opening. - take 15 units at mealtime three times daily take additional units as follows:	01750			

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01750	Continued From page 27 - 150-200 add two units - 201-250 add four units - 251-300 add six units - greater than 300 add eight units - if glucose less than 90 reduce to ten units - if glucose less than 60 hold NovoLog - do not give if not eating, regardless of pre-meal insulin Lantus pen (100 units/ml, long-acting insulin pen) ten units: pen is light blue inject ten units SQ before bedtime. - use a new needle for each injection. Prime the pen before every dose is given by dialing the pen to two units, point the pen up, and press the plunger button down until the two units comes out. Then dial up the number of units ordered and administer. Unopened pens are stored in refrigerator. Use date open sticker. Expires 28 days after opening. R11's prescriber order dated November 17, 2024, included the above orders. On July 22, 2025, at 7:16 a.m., the surveyor observed ULP-H prepare R11's Novolog pen and hand the pen to R11. R11 inserted the needle through his (R11) shirt into his upper left abdomen. R11's assessment dated April 29, 2025, included: can administer injections - resident may administer insulin if staff draw it up for him. R11's MAR did not include specific instructions for Novolog and Lantus administration to include injection site location or that R11 could self-administer insulin. On July 22, 2025, at 9:48 a.m., clinical nurse	01750			

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01750	Continued From page 28 supervisor (CNS)-C stated it was difficult to document insulin injection sites used in the computer system the licensee had. CNS-C stated insulin injection sites were not documented for any of the licensee's residents. In addition, CNS-C stated R11's record did not include specific instructions that R11 could self-administer insulin. CNS-C stated R11's medication assessment needed to be updated, but currently R11's assessment noted R11 could self-administer insulin. The manufacturer's instructions for insulin Novolog dated January 2019, noted rotate injections between injection spots: - stomach, except for the two inches around the belly button - top and outside of thighs, except in the bony area close to the knees - back of the upper area (might work best if someone else is injecting) - top and outside of the buttocks - do not inject into the same spot every time. The manufacturer's instructions for Lantus dated 2022, noted change (rotate) injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. R8 R8's diagnoses included heart failure, anemia, chronic inflammatory lung disease (COPD/ causes obstructed airflow from the lungs) and dependence on supplemental oxygen. R8's Service Plan dated July 8, 2025, indicated R8 received medication administration. On July 22, 2025, at 7:34 a.m., the surveyor	01750			

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01750	Continued From page 29 observed ULP-H administer R8's morning oral medication and hand R8 a Flonase (allergies) nasal spray container. R8 shook the container and instilled one spray into each nostril. R8's MAR dated July 1, 2025, thought July 23, 2025, included: - Flonase 50 micrograms (mcg) daily. Instill two sprays nasally one time a day. Shake gently before each use. alternate nostrils with each spray - alendronate 70 mg tablet (Fosamax/bone disease/slowing down bone loss) take one table by moth every seven days. Take with plain water in the morning. R8's prescriber order dated May 22, 2025, included the above orders. R8's assessment dated June 11, 2025, lacked inclusion of nasal medication. R8's MAR lacked specific instructions to include R8 could self-administer Flonase. In addition, R8's record lacked specific instructions for alendronate administration. On July 23, 2025, at 10:26 a.m., the surveyor and CNS-C reviewed R8's MAR and most current assessment. CNS-C stated that was "her bad" (missed the box on the assessment) for R8's nasal medication. CNS-C stated R8 was able to self-administer Flonase. CNS-C stated R8's record did not indicate R8 could self-administer nasal medication. CNS-C stated R8's record lacked specific instructions as required. On July 23, 2025, at 11:35 a.m., the surveyor reviewed the manufacturer's instructions for alendronate with CNS-C. CNS-C stated she	01750			

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01750	Continued From page 30 swore she included complete manufacturer's instructions in R8's record for alendronate. CNS-C reviewed R8's MAR and stated R8's MAR lacked complete specific instructions for alendronate as required. The manufacturers' instructions for alendronate dated 2000, noted do not eat, drink, or take other medicines or supplements before taking alendronate. Wait for at least 30 minutes after taking alendronate to eat, drink, or take other medicines or supplements. Do not lie down for at least 30 minutes after taking alendronate. Do not lie down until after your first food of the day. The licensee's Medication Management Services policy dated March 18, 2020, noted the registered nurse would conduct a face-to face assessment with the client (resident) and develop an individualized medication management plan included documentation of specific resident instructions relating to the administration of medications. The licensee's Insulin policy dated March 18, 2020, noted ask or assist the client in choosing an injection site. Rotating locations in the regions of the abdomen, buttocks, upper back arms, and thigh are recommended. The licensee's Nose Drop & Nasal Spray policy dated March 18, 2020, noted: 1. push up the nostrils gently with the end of the spray nozzle to provide easier entrance for the solution 2. follow prescriber orders and manufactures directions for nasal spray administration. No further information was provided.	01750			

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01750	Continued From page 31	01750			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-H) followed registered nurse (RN) written instructions for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760			

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01760	Continued From page 32 The findings include: R8's diagnoses included heart failure, anemia, chronic inflammatory lung disease (COPD/ obstructed airflow from the lungs) and dependence on supplemental oxygen. R8's Service Plan dated July 8, 2025, indicated R8 received medication administration. R8's medication administration record (MAR) dated July 1, 2025, through July 23, 2025, included: - Trelegy Ellipta (COPD) 25 micrograms (mcg) inhale one puff into the lungs one time a day. Rinse mouth after use. R8's prescriber order dated May 22, 2025, included the above order. On July 22, 2025, at 7:34 a.m., the surveyor observed ULP-H hand R8 a medication cup that contained R8's oral morning medications. ULP-H handed R8 a nasal medication and R8 inhaled the medication. ULP-H handed R8 a Trelegy inhaler. R8 placed the inhaler up to her lips and inhaled. The surveyor did not observe ULP-H offer or encourage R8 to rinse R8's mouth after administration of the Trelegy inhaler. On July 22, 2025, at 7:37 a.m., ULP-H stated some (residents) will rinse and some won't (rinse). ULP-H added R8 would not rinse after inhaler use. ULP-H added she had tried in the past. ULP-H confirmed she did not offer/ encourage R8 to rinse mouth after Trelegy use that day. The surveyor and ULP-H reviewed R8's record. R8's record included the instructions to rinse mouth after use. ULP-H stated she "just knew" R8 would refuse.	01760			

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01760	Continued From page 33 On July 22, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-C stated she "knew" the resident, and added ULP-H should have asked/ encouraged R8 to rinse mouth after inhaler use. The licensee's Medication Management Services policy dated March 18, 2020, noted medication management services proved by unlicensed personnel would be performed consistent with Minnesota assisted living licensee, including prior training and competency testing supported in the client's individualized medication management plan. Prior to delegating medication administration to ULPs, a RN must instruct and educate delegated staff on, the complete procedure of checking a client's (resident) medication administration record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R6,	01770			

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01770	Continued From page 34 R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 July 21, 2025, at 10:19 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the licensee provided medication set up services but it (medication set up) "varied". CNS-C sated there was one resident who received warfarin (blood thinner) and a pill strip was used for that set up. In addition, bubble packs were used when medications came in bottles from the VA (veteran's administration or prior to pharmacy cycle medication). On July 21, 2025, at 11:18 a.m., the surveyor reviewed the contents of a medication cart with CNS-C. The surveyor observed a seven-day medication planner set up for R6. CNS-C stated there was a note in R6's record that medication had been set up. R6 R6's diagnoses included atrial fibrillation (A-fib/an irregular and often very rapid heart rhythm that can lead to blood clots in the heart) and a history of pulmonary embolism (blood clots). R6's service plan dated March 31, 2025, indicated R6 received medication set up one time	01770			

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01770	Continued From page 35 weekly. On July 23, 2025, at 9:36 a.m., the surveyor observed ULP-H check in with R6 who was doing exercises in the common's area. ULP-H stated she had already administered R6's morning medication. R6's medication administration record (MAR) dated July 1, 2025, through July 22, 2025, included: - warfarin, two milligrams (mg) Tuesday, Wednesday, Friday, Saturday, Sunday - no warfarin Monday and Thursday, recheck August 12, 2025, (purple tablet in Medi planner). R6's prescriber order dated March 21, 2025, included the above orders. R6's record included, service, medication setup nurse, active November 5, 2024, assigned to registered nurse (RN) assignment, scheduled Tuesday at 10:00 a.m., - setup medications for resident: re-order and deliver refills as needed. Set up warfarin (Coumadin) in medication strip. No warfarin on Mondays & Thursdays: two mg warfarin all other days. Next INR (blood test measurers how long it takes for blood to clot) due August 12, 2025. R6's record included notes: July 1, 2025: medication set up in medication strip for the next seven days (completed by CNS) July 8, 2025: medication set up in medication strip for the next seven days. Will continue to monitor (completed by CNS). R6's record lacked medication set up documentation to include the name of medication, quantity of dose, times to be	01770			

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01770	Continued From page 36 administered, and route of administration. R8 R8's diagnoses included heart failure, anemia, chronic inflammatory lung disease (COPD/ causes obstructed airflow from the lungs) and dependence on supplemental oxygen. R8's Service Plan dated July 8, 2025, indicated R8 received medication administration. On July 22, 2025, at 7:34 a.m., the surveyor observed ULP-H administer R8's morning oral medication using correct technique. R8's MAR dated July 1, 2025, through July 23, 2025, included: started July 7, 2025 - metoprolol succinate ER (daily) take one tablet by mouth once daily for 30 days, 8:00 a.m. R8's prescriber order dated May 22, 2025, included the above order. R8's record included: medication nurse note, dated June 26, 2025 - writer (CNS-C) set up 30 days of the resident's dose of metoprolol succinate (heart) 200 mg tablets in bubble pack. One table placed in each bubble to be administered by staff per the MAR. Will continue to monitor. R8's record lacked medication set up documentation to include the times to be administered (8:00 a.m.), and route of administration (by mouth). On July 22, 2025, at 8:36 a.m., licensed assisted living director (LALD)-A stated the licensee "bubbles" some medications (puts medications into medication cards for ULPs to administer).	01770			

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01770	Continued From page 37 LALD-A was not sure of which resident's had medication put into bubbles. On July 22, 2025, at 9:50 a.m., CNS-C stated she bubbled medications for both R8 and R7. The surveyor reviewed R8's record with CNS-C. CNS-C stated MARs were not used to document medication set up and resident records would lack required information in regard to medication set up. The licensee's Medication Administration-Weekly Dosage Box Set Up policy dated March 18, 2020, noted 1. A licensed nurse would assure the medication orders were transcribed onto the electronic medication administration record (EMAR). a. medication name and strength b. visual description of medication c. day and time of administration d. route of administration e. drug classification and special precautions 2. for medications included in the dosage box, the day and time of administration would be noted on the eMAR, to direct staff to the order of the box. When the licensed nurse had completed setup up the medications into the dosage box, the set-up was documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01890 SS=F	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	01890			

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01890	Continued From page 38 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for two of two medication storage areas (secured unit, non-secured). In addition, the licensee failed to monitor for expired medication in one of two medication storage areas (non-secured). 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: SECURED UNIT On July 21, 2025, at 11:00 a.m., the surveyor, licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-B reviewed the contents of the medication storage area. LALD-A and ULP-B observed and confirmed the following: TIME SENSITIVE INFORMATION - opened fluticasone propionate 250/50 micrograms (mcg) inhaler (chronic obstructive pulmonary disease (COPD/ progressive lung	01890			

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01890	Continued From page 39 disease characterized by long-term respiratory symptoms and airflow limitation) lacked an open or expiration date for R2 - opened timolol (high eye pressure) eye solution lacked an open or expiration date for R3 - opened Lantus 100 milliliters (mg)/unit (long-acting insulin) lacked an open or expiration date for R4 - opened fluticasone propionate and salmeterol (COPD) 100/50 mcg inhaler lacked an open or expiration date for R5. NON-SECURED UNIT On July 21, 2025, at 11:18 a.m., surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the medication storage area. CNS-C observed and confirmed the following: COMPLETE AND LEGIBLE MEDICATION INFORMATION - opened glargine insulin 300 units/ml (long acting) lacked pharmacy label, to include the original prescription to include resident's name - opened Toujeo Solostar (glargine) 300 units/ml lacked a legible label for R7 - opened Trelegy Ellipta (COPD)100 /62.5 mcg inhaler lacked pharmacy label, to include the original prescription to include resident's name for R8. TIME SENSITIVE INFORMATION - opened glargine 300 unit/ml insulin, lacked an open or expiration date (unidentified resident) - opened Toujeo Solostar (glargine) 300 units/ml lacked an open or expiration date for R7 - opened Trelegy Ellipta 100/62.5 mcg inhaler lacked an open or expiration date for R8 - opened aspart insulin (short acting) insulin 100 ml/unit was dated July 18, (no year noted) lacked expiration date for R7	01890			

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01890	Continued From page 40 - opened fluticasone propionate and salmeterol inhaler included an opened date of July 5, (year not noted) lacked expiration date for R10 - opened Breztri (COPD) inhaler included an opened date of July 5, (year not noted) lacked expiration date for R9. EXPIRED MEDICATION - opened ipratropium bromide and albuterol inhalation solution (lung diseases) expired June 2025 for R10 - one opened nystatin topical (fungus) powder for R17 expired June 2025 - two unopened nystatin containers for R17 expired June 2025. Directly after the above observation CNS-C stated medication storage per manufacturer's recommendation was a widespread issue. The manufacturer's instructions for fluticasone propionate dated January 2020, noted write the date you opened the pouch on the first line of the label and the "use by" date on the second line of the label. The "use by" date is one month after the date you opened the pouch. The manufacturer's instructions for timolol dated August 2018, noted write the date on the bottle when you open the eye drops and throw out any remaining solution after four weeks. The manufacturer's instructions for Lantus dated 2022, noted after 28 days throw your opened Lantus pen away, even if it still has insulin in it. The manufacturer's instructions for fluticasone propionate and salmeterol dated February 1, 2024, noted the inhaler has a window that shows the number of doses remaining. This tells you	01890			

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01890	Continued From page 41 when you are getting low on medicine. The dose counting down from 20 to 0 will show up in red to remind you to refill your prescription. Throw away the inhaler when the dose counter displays 0, 30 days after opening the pouch. The manufacturer's instructions for Trelegy Ellipta dated February 3, 2025, noted, "discard Trelegy Ellipta six weeks after you have taken it out of the foil pouch, or if the dose indicator shows a zero, whichever comes first." The manufacturer's instructions for aspart insulin dated August 15, 2023, noted can be used for 28 days, but after that time it must be discarded. The manufacturer's instructions for glargine (Toujeo) insulin dated October 2022, noted after you open the insulin, if it has been 56 days since the first use, dispose of the pen properly. Even if there is still insulin inside. The manufacturer's instruction for Breztri dated May 2025, noted store Breztri in the unopened foil pouch and only open when ready to use. Safely throw Breztri away in the trash, three weeks after you open the foiled pouch (for the 28-inhalation canister) or three months after you open the foil pouch (for the 120-inhalation canister), or when the counter reads "0". The licensee's Storage of Medications policy dated March 18, 2020, noted all medication are stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R5, R11) receiving treatments. In addition, the licensee failed to ensure prior to delegating nursing tasks, the RN trained two of two unlicensed personnel (ULP-I, ULP-G) and had ULP demonstrate the ability to follow the procedure to perform the tasks using ice/warm packs for two of two residents (R5, R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01950			

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01950	Continued From page 43 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: SPECIFIC INSTRUCTIONS On July 21, 2025, at 10:20 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the licensee provided the service of blood glucose monitoring. CNS-C stated both finger prick (poke) and non-invasive type (system that measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm) systems were used at the facility to monitor blood glucose. R5 R5's diagnosis diabetes included cognitive impairment, dementia, and mood disorder. R5's service plan dated September 30, 2024, indicated R5 received daily blood glucose monitoring, and weekly weight monitoring. R5's prescriber's order dated April 30, 2025, included the above orders. BLOOD GLUCOSE MONITORING R5's service record, active on January 29, 2025, included: blood glucose monitoring daily - staff will perform blood glucose checks, following agency procedure, as ordered by the provider. Document results and report any abnormal results out of range to the nurse, as determined by the provide or standard range	01950			

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01950	Continued From page 44 below 70 or over 300. R5's record included blood glucose dated July 1, 2025, through July 16, 2025, ranged from 101 to 190. R5's record did not include specific instructions to include which type of blood glucose monitoring system was used for R5. On July 22, 2025, at 6:16 a.m., the surveyor reviewed R5's record with ULP-I. ULP-I stated R5's record did not note which type of blood glucose monitoring system was used, finger poke or non-invasive type. ULP-I stated both systems were used at the facility. ULP-I stated it could be personal preference or doctors order for the system used. ULP-I stated R5 used the finger poke system. On July 22, 2025, at 6:19 a.m., the surveyor observed ULP-I apply gloves, and gather supplies (blood glucose meter [device that will test blood sample to determine blood glucose level], testing strip, lancet pen [small needle, attached to a pen type of device, used to poke the skin -usually on a finger] and alcohol pads). ULP-I took the gathered equipment to R5 who was seated at a dining room table in the open commons area. ULP-I massaged the pointer finger on R5's left hand. ULP-I cleaned R5's left pointer finger with an alcohol pad. ULP-I used the lancet pen to obtain a drop of blood. ULP-I placed the drop of blood onto the blood glucose test strip to obtain a reading of 112. On July 22, 2025, at 2:17 p.m., R5's record was reviewed with operations director/registered nurse (OD/RN)-D. OD/RN-D stated she felt "silly." OD/RN-D asked the surveyor if R5 had a finger	01950			

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01950	Continued From page 45 poke or non-invasive type of blood glucose monitoring preformed? OD/RN-D not sure what abbreviations on MAR were/meant). OD/RN-D stated R5's record lacked specific instructions for blood glucose monitoring, to include which type of system was used for R5. WEIGHT MONITORING R5's service record, active on March 16, 2022, included: weight monitoring, Tuesday - monitor and record resident weight. R5's record included recorded weights dated July 1, 2025, though July 22, 2025, that ranged from 226.2 to 240 pounds. On July 22, 2025, at 7:45 a.m., the surveyor observed ULP-G monitor R5's weight to obtain a weight of 240 pounds. R5's record was reviewed with ULP-G. ULP-G stated R5's record did not note when or what to report to nursing in regard to R5's weight. On July 23, 2025, at 11:39 a.m., CNS-C stated R5 was put on weekly weights to monitor encouraged weight lost. R5's record was reviewed with CNS-C. CNS-C stated R5's record did not include specific instructions for when ULPs should report R5's weight to nursing. R11 R11's diagnoses included diabetes, cataract of both eyes, and major depressive disorder. R11's service plan dated May 14, 2025, indicated R11 received the following services: blood glucose monitoring, daily weight, and eye compress application. R11's prescriber order dated November 19, 2024,	01950			

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01950	Continued From page 46 included the above orders. BLOOD GLUCOSE R11's service record, active on January 29, 2024, included: blood glucose monitoring - staff will perform blood glucose checks, following agency procedure, as ordered by the provider. Document results and report any abnormal results out of range to the nurse, as determined by the provide or standard range below 70 or over 300. On July 22, 2025, at 7:15 a.m., the surveyor observed ULP-H ask R11 what R11's blood glucose was. R11 showed ULP-H his phone and stated his blood glucose was 184. R11's record did not include specific instructions to include which type of blood glucose monitoring system was used for R11. WEIGHT MONITORING R11's service record, active on October 16, 2024, included: weight monitoring, daily at a.m. (morning) - monitor and record resident weight. (specify scale to be used and notification parameters: (blank). On July 23, 2025, at 11:40 a.m., R11's record was reviewed with CNS-C. CNS-C stated R11's record did not note which type of blood glucose monitoring system was used or that R11's phone was linked to his blood glucose monitoring system and R11's record did not include when or what to report to nursing in regard to R11's weight. CNS-C confirmed R5 and R11's records lacked specific instructions. EYE COMPRESS	01950			

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01950	Continued From page 47 R11's service record, active on March 26, 2025, included eye compress daily Instructions: staff will assist resident to apply an eye compress as ordered by provider. Include resident instructions below: Follow there instructions at least two times per day. 1. Apply a warm compress over your closed eye for a few minutes to loosen the crusty deposits on your eyelids. Firmly but gently massage the eyelids, using a clean washcloth or a clean finger 2. Immediately use a clean washcloth or cotton-tipped applicator moistened with warm water and a few drops of diluted baby shampoo or an over-the-counter eyelid cleanser to wash awry oily debris or scales at the base of your eyelashes. To do this, gently pull your eyelid way from your eye and use the washcloth to gently rub the base of the lashes. this helps avoid damaging your cornea with the washcloth 3. Rinse your eye lids with warm water and gently pat them dry with a clean, dry towel. R11's record lacked specific instructions for R11's treatment of eye compress to include what and when to report to nursing. On July 23, 2025, at 11:32 a.m., R11's record for eye compress was reviewed with CNS-C. CNS-C stated she took the instructions for R11's eye compress from prescriber order and put those instructions into R11's record. CNS-C stated R11's record did not include when or what ULPs should report to nursing in regard to eye compress. CNS-C stated an order to discontinue R11's eye compress was in process. TRAINING AND DEMONSTRATION OF COMPETENCY ULP-I ULP-I was hired on February 10, 2025, to provide	01950			

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01950	Continued From page 48 direct care services to the facility's residents. On July 22, 2025, at 6:19 a.m., the surveyor observed ULP-I assist R5 with daily services. ULP-I's record lacked evidence of receiving training and demonstration of competency for cold packs and warm packs. R5's records indicated the use of ice/warm packs. ULP-G ULP-G was hired on March 25, 2025, to provide direct care services to the facility's residents. On July 22, 2025, at 9:56 a.m., the surveyor observed ULP-G and ULP-J assist R12 into a Broda wheelchair. ULP-G adjusted the chair tilt. ULP-G's record lacked evidence of receiving training and demonstration of competency for cold packs and warm packs. R12's records indicated the use of ice/warm packs. R5 R5's medication administration record (MAR) dated July 1, 2025, thought July 22, 2025, included: - ice/warm pack:15 minutes on and 15 minutes off as needed (PRN) R5's prescriber's order dated April 30, 2025, included the above order. R12 R12's diagnoses included Alzheimer's with behavioral disturbance, anxiety, frail elderly, muscle weakness, sleep disorder, generalized weakness, and age-related osteoporosis without current pathological fracture (reduced bone mass, decrease in thickness resulting in	01950			

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01950	Continued From page 49 increased fracture incidence). . R12's MAR dated July 1, 2025, through July 23, 2025, included: - ice/warm pack, apply to affected areas 15 minutes on, 15 minutes off, three times PRN. R12's prescriber order dated February 5, 2025, included the above order. On July 22, 2025, at 2:18 p.m., R5 and R12's records were reviewed with operations director/registered nurse (OD/RN)-D. OD/RN-D stated she was "thinking it (ice/warm packs) went on (MARs) and never went off (removed from MAR/record). OD/RN-D stated she was not aware of ice/warm pack training. OD/RN-D stated ULPs could apply ice/warm packs to R5 and R12 as the service was in R5 and R12's records (on MAR) and there were prescriber's order for ice/warm packs. OD/RN-D asked clinical nurse supervisor (CNS)-C if the task of ice/warm packs had been reviewed with ULPs (training and competency completed). CNS-C stated she could not remember if she had reviewed the task with ULPs. The surveyor asked CNS-C to send training records to the surveyor by noon the following day if the training and competency was located. The surveyor did not receive training records to include ice/warm pack training for ULP-I or ULP-G, or another ULP. The licensee Medication, Treatment and Therapy Administration by Unlicensed Personnel policy dated March 16, 2020, noted unlicensed personnel that would provide assistance with treatment and therapy administration would be trained and competency tested by the RN on the following: - administration of treatment and therapy to the	01950			

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01950	Continued From page 50 client (resident) - the procedure for staff to notify the RN - the RN had developed written, specific instruction for each client - the RN had communicated with the unlicensed personnel about the individual needs of the client. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
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: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for one of three residents (R8) with an assistive device (consumer bedrail). Further, the licensee failed to	02310			

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02310	Continued From page 51 provide care and services according to acceptable health care, medical, or nursing standards for storage of hydrogen peroxide (first aid antiseptic) in one of one laundry room, in one of two units (secured unit). 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: This resulted in an immediate correction order on July 22, 2025. Correction order amended on July 28, 2025, to add additional information. R8's diagnoses included heart failure, anemia, chronic inflammatory lung disease (COPD/ causes obstructed airflow from the lungs) and dependence on supplemental oxygen. R8's Service Plan dated May 19, 2025, indicated R8 received assistance with oxygen management, safety checks, monthly vital sign monitoring, medication reminders, and housekeeping services. R8's assessment dated June 11, 2025, included: - mobility - bed: independent- no assistance needed with bed mobility - mobility - transfer: independent- no assistance needed with transferring	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS			STREET ADDRESS, CITY, STATE, ZIP CODE 518 7TH AVENUE NE AITKIN, MN 56431		
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02310	Continued From page 52 - mobility - ambulation: independent- no assistance needed with ambulation - mobility - needs an assistive device to transfer: walker four wheeled walker. On July 21, 2025, at approximately 3:45 p.m., clinical nurse supervisor (CNS)-C stated there were no consumer bedrails at the facility. On July 22, 2025, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-H prepare R8's morning medication. ULP-H took R8's medications to R8's room. R8 was seated in a recliner chair wearing a nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen). The surveyor observed consumer bedrail on the side of bed R8 would exit from. On July 22, 2025, at 7:37 a.m., R8 stated she (R8) used the bed rail attached to R8's bed, while in bed, and to transfer from bed. On July 22, 2025, at 9:19 a.m., CNS-C stated she was not aware that R8 had a bedrail. On July 22, 2025, at 9:29 a.m., CNS-C observed a consumer rail on the side of the bed R8 would exit from. CNS-C bent down to look at the consumer rail. CNS-C stated a bedrail assessment had not been completed as required for the consumer bedrail on R8's bed. R8's record lacked a comprehensive assessment for the use of an assisted device (bedrail) including the risks of the bedrail were reviewed and understood, the installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2025
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02310	Continued From page 53 bedrail and mattress for areas of entrapment, stability, correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information The licensee's Side Rails policy dated March 18, 2020, noted when the licensee was aware a home care client (resident) was utilizing side rails (bedrails/medical device) on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and unitized consisted with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the siderail. The FDA "A Guide to Bed Safety" revised April 2010, included the 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), last updated February 17, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail	02310			

Minnesota Department of Health

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02310	Continued From page 54 to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. STORAGE OF HYDROGEN PEROXIDE On July 22, 2025, at 5:35 a.m., the surveyor observed the door to the laundry room in the secured unit open and a container of hydrogen peroxide 5%, on an open shelf in the laundry room, above eye level. The surveyor observed R15 seated in the common's area and R4	02310			

Minnesota Department of Health

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02310	Continued From page 55 ambulating in the hallway. On July 22, 2025, at 5:41 a.m., ULP-F stated the laundry door was left open so the drier could be heard. ULP-F stated the laundry door was to be secured. ULP-F secured the laundry room door. On July 22, 2025, at 9:38 a.m., CNS-C stated the laundry room door was to be secured. CNS-C stated she believed the buzzer on the drier could be turned up and commented ULPs could use timer also to alert them of the completion of the drier cycle. LALD-A commented she was unsure as to why the hydrogen peroxide was in the laundry room, and not in the blood spill kit. Hydrogen peroxide Safety Data Sheet, dated September 9, 2024, noted: - harmful if swallowed - causes serious eye damage - wear eye protection/face protection - if swallowed: call a poison center/doctor if you feel unwell. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE	02310			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2025
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02410	Continued From page 56 (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 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, interview and record review, the licensee failed to ensure privacy was maintained for one of three residents (R5) while receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02410			

Minnesota Department of Health

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02410	Continued From page 57 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included cognitive impairment, dementia, diabetes, and mood disorder. R5's service plan dated September 30, 2024, indicated R5 received daily blood glucose monitoring. On July 22, 2025, at 6:19 a.m., the surveyor observed unlicensed personnel (ULP)-I apply gloves, and gather supplies (blood glucose meter [device that will test blood sample to determine blood glucose level], testing strip, lancet pen [small needle, attached to a pen type of device, used to poke the skin -usually on a finger] and alcohol pads). ULP-I took the gathered equipment to R5 who was seated at a dining room table in the open commons area. The surveyor observed R14 seated in the commons area and an unidentified resident wandering in the secured unit. The surveyor did not observe ULP-I offer or encourage R5 to go to a private area, nor did the surveyor observe ULP-I ask R5 if R5's blood glucose could be monitored in the commons area. ULP-I massaged the pointer finger on R5's left hand. ULP-I cleaned R5's left pointer finger with an alcohol pad. ULP-I used the lancet pen to obtain a drop of blood. ULP-I commented, "holy cow, that is not enough" (blood). ULP-I placed the drop of blood onto the blood glucose test strip to obtain a reading of 112. ULP-I wiped R5's left pointer finger with the alcohol pad. On July 22, 2025, at 6:53 a.m., ULP-I stated "we" (ULPs) do not ask residents if they mind if their (resident) blood glucose monitoring was	02410			

Minnesota Department of Health

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02410	Continued From page 58 completed in the commons area of the "memory care" (secured unit). On July 22, 2025, at 9:42 a.m., clinical nurse supervisor (CNS)-C stated she would prefer that blood glucose monitoring not be done at the dining room table, in the commons area. CNS-C stated she had spoken to ULPs about that (to provide privacy). The licensee's Blood Sugar Testing policy dated March 18, 2020, noted provide privacy for the procedure. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. Residents have the right to respect and privacy regarding the resident's service plan. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for residents' safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Golden Horizons
528 7th Ave NE
Aitkin, MN 56431
Parcel:

Phone:

License Info

License: HFID 30395

Risk:
License:
Expires on:
CFPM: SEAN WEIMER
CFPM #: ; Exp: 5/9/2029

Inspection Info

Report Number: F1017251066
Inspection Type: Full - Single
Date: 7/22/2025 Time: 12:37:06 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: EMAILED

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3* CFP#: 2

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

COMMENT: SEAN WEIMER HAS COMPLETED THE SERVE SAFE CLASS, SUBMIT SERVE SAFE CREDENTIAL FOR STATE ISSUED CERTIFICATE.

Comply By: 7/22/2025 Originally Issued On: 7/22/2025

Food & Beverage General Comment

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1017251066 from 7/22/2025

SEAN WEIMER
KITCHEN MANAGER


Nate Topp,
Public Health Sanitarian 2
320-223-7333
nate.topp@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

Golden Horizons
Aitkin
County/Group:

Inspection Info

Report Number: F1017251066
Inspection Type: Full
Date: 7/22/2025
Time: 12:37:06 PM

Food Temperature: Product/Item/Unit: Rice; **Temperature Process:** Hot-Holding

Location: oven at 173 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Beans ; **Temperature Process:** Hot-Holding

Location: oven at 188 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Beef Taco Meat; **Temperature Process:** Re-Heating

Location: oven at 88 Degrees F.

Comment: 1 Hour into reheat.

Violation Issued?: No



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Inspection Info

Golden Horizons
Aitkin
County/Group:

Report Number: F1017251066
Inspection Type: Full
Date: 7/22/2025
Time: 12:37:06 PM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** PPM
Comment: 50 PPM
Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1017251066		Food Establishment Inspection Report		Page 1 of 1	
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		1	Date: 7/22/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 12:37:06 PM
		Score (optional)			Dur: min
Establishment: Golden Horizons		Address: 528 7th Ave NE		City/State: Aitkin, MN	Zip: 56431
License/Permit #: HFID 30395		Permit Holder:		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status		COS	R		
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	OUT	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	IN	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	IN	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food			
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions 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" or OUT 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	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	IN	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/O	Plant food properly cooked for hot holding			
35	N/O	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature) 					
Follow-up: Follow-up Date:					