Electronically Delivered

April 9, 2025

Licensee
Golden Pond Crystal
3648 Colorado Avenue North
Crystal, MN 55422

RE: Project Number(s) SL33571016

Dear Licensee:

On February 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 20, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

KKM

Electronically Delivered

January 3, 2025

Licensee
Golden Pond Crystal
3648 Colorado Avenue North
Crystal, MN 55422

RE: Project Number(s) SL33571016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33571	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CRYSTAL	3648 COLORADO AVENUE NORTH CRYSTAL, MN 55422

(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: SL33571016-0 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; all receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-D) observed to provide wound care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 20, 2024, at 10:47 a.m., with R1's permission, the surveyor observed ULP-D while providing wound care to R1's heel. ULP-D	0 510		

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0 510	Continued From page 4 washed his hands and donned (put on) gloves. R1 was lying in the bed on his left side. ULP-D removed the gauze dressing wrapped around R1's heel, folded it, and placed it beside R1's leg on the disposable bed pad. ULP-D used a gauze pad with Vashe (wound cleanser) to gently clean the large open wound on the heel, and the surrounding skin. R1 denied pain. Without removing the soiled gloves, ULP-D used a clean gauze pad to dry the area. ULP-D squeezed some ointment from a tube onto a new gauze pad and placed it over the wound, and began wrapping the foot with a gauze roll. Clinical nurse supervisor (CNS)-A came into the room and directed ULP-D to pack the wound with gauze soaked with Vashe, and then to cover with a high absorbency pad, before wrapping with the gauze roll, which ULP-D did. When finished and without removing the soiled gloves, ULP-D picked up the box of gauze pads, the box containing the ointment, and the scissors, and placed them into a small plastic basket that held the supplies. ULP-D folded up the disposable bed pad and threw it in the trash, picked up the plastic basket and placed it on a shelf by the television, and picked up the box of gloves from the bed and placed them on the shelf. ULP-D removed the gloves, put them in the trash, and walked into the kitchen to wash his hands. When interviewed on November 20, 2024, at 10:56 a.m., ULP-D stated he should have removed the gloves after removing the soiled dressings, performed hand hygiene, and donned clean gloves before redressing the wound. Also, ULP-D stated he should have removed the gloves when finished, and performed hand hygiene before putting away supplies. On November 20, 2024, at 10:59 a.m., CNS-A	0 510		

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0 510	Continued From page 5 stated the expectation was to remove gloves and perform hand hygiene after removing soiled dressings and after completing the task, before touching the supplies and other items. The licensee's Infection Control-Gloves policy, dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. The procedure included: -wash hands; -apply gloves to both hands; -remove contaminated materials; -place materials in proper receptacle; -remove gloves; -dispose used gloves in proper receptacle; and -rewash hands. The licensee's Hand Washing policy, dated August 1. 2021, indicated proper hand washing techniques should be used to protect against the spread of infection, and directed hand washing shall be completed: - immediately before touching a resident; - before touching a resident's immediate environment; - after contact with blood, body fluids, or contaminated surfaces; - immediately after glove use; - before, during, and after preparing food; - before eating food; - before and after caring for someone who is sick; - before and after treating a cut or wound; - after using the toilet; - after changing incontinent products or cleaning up after someone who has used the toilet; - after blowing your nose, coughing, or sneezing; and - after touching garbage. Also included, handwashing will be performed by	0 510		

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0 510	Continued From page 6 all employees, as necessary, between tasks and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 630		

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0 630	Continued From page 7 affect a large portion or all of the residents). The findings include: R1's diagnoses included spastic tetraplegia (spinal cord injury), neurogenic bowel and bladder (a condition that affects control due to damage to the brain, spinal cord, or nerves), and left heel ulcer and cellulitis. R1's record lacked a Service Plan. R1's Assisted Living Resident Care Plan, dated September 30, 2024, indicated R1 required assistance with dressing and obtaining clothing, bathing, toileting, transferring, range of motion, and housekeeping. R1's Master Care Plan, dated August 20, 2024, indicated R1 was at risk to abuse other vulnerable adults and had history of aggressiveness, and included specific measures to minimize the risk. The care plan also noted R1 was at risk to abuse himself with severe deficits in judgement and self-care and included specific measures to minimize the risk. R1's IAPP failed to include: - the person's susceptibility to abuse by another individual, including other vulnerable adults. On November 19, 2024, at 11:27 a.m., clinical nurse supervisor (CNS)-A stated she needed to contact the electronic medical records vendor to have the above required statement added to the assessment. CNS-A stated the same format was used for all residents, therefore, this was missing from all residents. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated August 1,	0 630		

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0 630	Continued From page 8 2021, indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify vulnerability risks and developed measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). This included completion of a two-step TST (tuberculin	0 660		

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0 660	Continued From page 9 skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-C). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health), dated July 8, 2024, indicated the licensee's TB risk level was "low." ULP-C had a hire date of April 29, 2024, to provide services under the licensee's Assisted Living license to the licensee's residents. ULP-C's employee record included a Health and Mantoux Screen, dated April 29, 2024, and included results of one negative TST, dated May 1, 2024; however, ULP-C's employee record lacked results of a second TST, as required. On November 20, 2024, at 11:08 a.m., ULP-C stated he only had one TST when he started employment. On November 20, 2024, at 11:09 a.m., clinical nurse supervisor (CNS)-A stated she wasn't aware that two TSTs were required, and stated	0 660		

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0 660	Continued From page 10 she thought the employee only needed one TST if the first one was negative. The licensee's Tuberculosis Screening policy, dated August 1, 2021, indicated staff whose essential job functions require work within the same air space of residents would be screened and tested for tuberculosis prior to the staff being exposed to residents. The policy indicated new staff would be screened for active signs of TB and would have a blood test or a two-step TST conducted. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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GOLDEN POND CRYSTAL	3648 COLORADO AVENUE NORTH CRYSTAL, MN 55422

(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
0 680	Continued From page 11	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 12 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 November 18, 2024, at 2:06 p.m., clinical nurse supervisor (CNS)-A provided the black binder that contained the Emergency Preparedness Plan, and stated she located the binder in the basement. CNS-A stated it should be kept at the staff desk on the main level, where all residents resided. On November 19, 2024, at 1:33 p.m., the surveyor reviewed the licensee's Emergency Plan, dated February 1, 2023, which lacked evidence of the following required information: - annual reviews/updates of plan; - all-hazards approach, including emerging infectious diseases (EID), as applicable; - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - annual review/update on policies and procedures; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for sheltering in place for residents, staff, and volunteers who remain in the facility (policy indicated "ALF [assisted living facility] will not be used as a shelter for evacuation."; - development of policies and procedures for sewage and waste disposal;	0 680		

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0 680	Continued From page 13 -sharing information on occupancy/needs; and -emergency prep training and testing. On November 19, 2024, at 1:33 p.m., licensed assisted living director (LALD)-B stated the plan should include the above contents and was an ongoing process. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated June 1, 2021, indicated the plan would include all required elements of Appendix Z, and would be reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 14 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 730		

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0 730	Continued From page 15 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: R4's diagnoses included schizoaffective disorder (mental health condition), depression, anxiety, bipolar, and Parkinson's disease. R4 began receiving services on November 30, 2020, and was discharged on October 14, 2022. R4's progress notes, dated August 31, 2022, indicated R4 was transferred to the hospital due to agitation and behaviors. On October 19, 2022, R4 was presented a termination notice while still in the hospital, due to the licensee's inability to meet R4's needs. R4's record lacked a discharge summary. On November 20, 2024, at 1:06 p.m., clinical nurse supervisor (CNS)-A stated she was unable to locate R4's discharge summary and stated if it wasn't in the paper file, it probably wasn't done. The licensee's Resident Discharge Summary procedure, dated August 2021, indicated upon discharge, a discharge summary would be created and would include the following: - provide a summary of the resident's stay, including diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - provide a final summary of the resident's status from the latest assessment or review, including baseline and current mental, behavioral, and	0 730		

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0 730	Continued From page 16 functional status; and - provide a post-discharge care plan. The procedure directed the discharge summary would be provided to the resident, and with the resident's consent, the resident's representatives and case manager. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code. Per Minnesota State Fire Code provided egress windows did not meet the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 19, 2024, from approximately 12:13 p.m. to 2:05 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A During the tour, the surveyor asked CNS-A to open the windows in the resident sleeping rooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 1: One windows measuring 33.5 inches clear width, 15 inches	0 780		

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0 780	Continued From page 18 clear height, and 502.5 square inches total open area for each window. Resident sleeping room 3: One windows measuring 33.5 inches clear width, 16.5 inches clear height, and 552.75 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Resident sleeping room 2: Two windows measuring 30 inches clear width, 13 inches clear height, and 390 square inches total open area. The windows in resident sleeping rooms 1, 2, and 3 did not meet the minimum requirements for opening height. The windows in bedrooms 1, 2, and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to CNS-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On November 19, 2024, the surveyor explained to CNS-A that an immediate correction order was issued for the above findings. CNS-A contacted chief financial officer (CFO)-E regarding the noncompliant windows. CFO-E stated they understood the requirements for egress windows	0 780		

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0 780	Continued From page 19 and would immediately start the process of getting the windows replaced. CFO-E stated that a fire watch would be immediately implemented in the facility to mitigate risk from noncompliant windows. TIME PERIOD FOR CORRECTION: Immediate.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 20 The findings include: On November 19, 2024, from approximately 12:13 p.m. to 2:05 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the tour the surveyor observed the following. Resident sleeping room 4 had an electrical outlet that was missing a cover plate. Resident sleeping room 4 had a cabinet door that was not securely attached, and the hardware was separating, with door hanging loose from assembly. Resident sleeping room 4 had an electric heater in use that was not being used to manufacturer instructions including items stored on and around the device and insufficient clearance between device and other furniture. Resident sleeping room 4 had an unapproved multiplug adapter device in use. The laundry room had an unapproved multiplug adapter device in use to power washer, dryer and other appliances. During the facility tour interview on November 19, 2024, CNS-A verified the above listed physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 21 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, failed to provide required training, and failed to	0 810		

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0 810	Continued From page 22 conduct required evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 November 19, 2024, from approximately 12:13 p.m. to 2:05 p.m. clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility to the surveyor. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS-A was unable to provide documentation showing adequate training provided for staff on the fire safety and evacuation plan. The provided FSEP documents did not include accurate employee actions to be taken in event of a fire and referenced fire protection equipment not available at the facility such as "sprinklers," "smoke compartment" doors, and "automatic closers." The provided employee actions were not sufficient or accurate to the facility. The provided FSEP indicated the garage as an emergency exit which is not permitted as it is designated as an area of higher hazard. No	0 810		

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0 810	Continued From page 23 diagram of the basement area was provided. The provided FSEP documents did not include fire procedures for residents. The provided FSEP documents did not include evaluation of and procedures for unique resident needs. No evidence of resident training on FSEP was provided. Evacuation drill documents were provided which indicated that drills are performed exclusively during morning shift with morning shift staff. Drills were not occurring at the required rate of twice per year per shift. During an interview on November 19, 2024, from approximately 12:13 p.m. to 2:05 p.m., the surveyor explained the requirements for frequency of drills, employee trainings and FSEP documents and CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	0 900		

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0 900	Continued From page 24 (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 900		

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0 900	Continued From page 25 R1 was admitted on September 30, 2022, and received services under the licensee's assisted living license. R1's diagnoses included spastic tetraplegia (spinal cord injury), neurogenic bowel and bladder (a condition that affects control due to damage to the brain, spinal cord, or nerves), and left heel ulcer and cellulitis. R1's record lacked a Service Plan. R1's Assisted Living Resident Care Plan, dated September 30, 2024, indicated R1 required assistance with dressing and obtaining clothing, bathing, toileting, transferring, range of motion, and housekeeping. R1's record lacked a written contract that contained all the terms concerning the provision of: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. On November 19, 2024, at 1:11 p.m., licensed assistant living director (LALD)-B stated R1 never returned the signed contract or the service agreement. LALD-B stated R1 had a new guardian and would sign the necessary paperwork. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated when a prospective resident decided to move into the facility, a signed Assisted Living contract would be signed and received by the facility. No further information was provided.	0 900		

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0 900	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2	0 910		

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0 910	Continued From page 27 R2's start of services was September 21, 2018. R2's Residential Care Agreement, identified as the contract, was signed by R2 on December 3, 2021. R3 R3's start of services was December 1, 2018. R3's Residential Care Agreement, identified as the contract, was signed by R3 on December 4, 2021. R2 and R3's written contract included the facility's license number. The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On November 20, 2024, at 12:56 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they weren't aware that the contract should include the HFID number, instead of the license number. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information	0 920		

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0 920	Continued From page 28 (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 920		

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0 920	Continued From page 29 or has the potential to affect a large portion or all the residents). The findings include: R2 R2's start of services was September 21, 2018. R2's Residential Care Agreement, identified as the contract, was signed by R2 on December 3, 2021. R3 R3's start of services was December 1, 2018. R3's Residential Care Agreement, identified as the contract, was signed by R3 on December 4, 2021. R2 and R3's Residential Care Agreements indicated the facility was a "24-hour housing with services facility that does not provide dementia care licensed by the Minnesota Department of Health," rather than an assisted living facility license. R2 and R3's record lacked a written contract to include: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On November 20, 2024, at 12:56 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they didn't realize the contract listed the wrong type of licensure. The licensee's Signing an Assisted Living	0 920		

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0 920	Continued From page 30 Contract policy, dated August 1, 2021, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance	0 940		

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0 940	Continued From page 31 waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's start of services was September 21, 2018. R2's Residential Care Agreement, identified as the contract, was signed by R2 on December 3, 2021. R3 R3's start of services was December 1, 2018. R3's Residential Care Agreement, identified as the contract, was signed by R3 on December 4, 2021.	0 940		

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0 940	Continued From page 32 R2 and R3's Residential Care Agreement lacked the following required content: - the contact information to obtain long-term care consulting services under section 256B.0911. On November 20, 2024, at 12:56 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they weren't aware of the required contents for the contract. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950		

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0 950	Continued From page 33 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents (R2, R3) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's start of services was September 21, 2018. R2's Residential Care Agreement, identified as the contract, was signed by R2 on December 3, 2021. R3	0 950		

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0 950	Continued From page 34 R3's start of services was December 1, 2018. R3's Residential Care Agreement, identified as the contract, was signed by R3 on December 4, 2021. R2 and R3's Residential Care Agreement lacked the following required verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On November 20, 2024, at 12:56 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they weren't aware of the required verbatim notice. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, did not address the required contents of the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 35 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 36 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-C, ULP-D) to include all required content. This had the potential to affect all of the licensee's 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). The findings include: ULP-C ULP-C was hired on April 29, 2024, to provide direct care services to residents of the facility. ULP-C's employee record lacked documentation of training and competency evaluations for the following: - understanding appropriate boundaries between staff and residents and the resident's family. ULP-D ULP-D was hired on November 15, 2023, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of training and competency evaluations for the following:	01370		

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01370	Continued From page 37 - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - training on the prevention of falls; and - understanding appropriate boundaries between staff and residents and the resident's family. On November 20, 2024, at 11:30 a.m., licensed assisted living director (LALD)-B stated she was aware of the required competencies, and stated she didn't know why the training record wasn't complete. The licensee's Competency Training Evaluations policy, dated August 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP will include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01370		

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01370	Continued From page 38 devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 39 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 40 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on November 15, 2023, to provide direct care services to residents of the facility. ULP-D's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following:	01470		

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01470	Continued From page 41 - principles of person-centered planning/service delivery. On November 20, 2024, at 11:35 a.m., licensed assisted living director (LALD)-B stated she was aware of the required orientation content and stated she didn't know why the training record wasn't complete. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents which must contain: - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 42 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 43 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training including all required topics for each twelve months of employment for one of one employee (clinical nurse supervisor (CNS)-A). This had the potential to affect all of the licensee's 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). The findings include: CNS-A began her employment with the licensee on March 17, 2017, to provide direct service to the licensee's residents and supervision of the licensee's staff. CNS-A's employee records lacked the following required annual training content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 20, 2024, at 11:30 a.m., licensed assisted living director (LALD)-B stated she was aware of the required content of the annual	01500		

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01500	Continued From page 44 training, and stated she didn't know why the training record wasn't complete. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01620		

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01620	Continued From page 45 review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current smoking status for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 November 19, 2024, 10:15 a.m., the surveyor observed as unlicensed personnel (ULP)-C assisted R2 in his wheelchair, into the garage. ULP-C stated R2 was going out to the garage to smoke. R2's diagnoses included mood disorder, history of stroke, memory loss, disorientation, and chronic pain. R2's Service Plan (Waiver) - Addendum to Contract, dated November 6, 2024, unsigned, indicated R2 received services including morning and evening cares, activity assistance, ambulation assistance, bathing assistance, behavior monitoring, continence care, medication administration, safety checks, transferring, and "Smoke break" seven times daily. R2's Individual Review, dated August 20, 2024, indicated R2 smoked every two hours from 9:00 a.m. to 9:00 p.m., and noted R2 smoked with	01620		

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01620	Continued From page 46 staff assist and supervision. R2's Resident Assessment Form, dated August 13, 2024, identified as 90-day assessment, indicated R2 was alert, oriented with forgetfulness, had left sided weakness, and had an occasional cough. The assessment lacked mention of R2's smoking, and did not include a smoking assessment that included the ability to smoke without causing burns or injury to the resident or others or damage to property, as required. On November 21, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-A stated R2 went out onto the deck in the back yard to smoke, but he was allowed to go into the garage to smoke when the weather did not permit being outside. CNS-A stated staff assisted R2 to smoke every two hours and stated R2 required supervision when smoking. CNS-A stated she had not completed a smoking assessment for R2. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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01640	Continued From page 47 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for one of one resident (R1), and failed to ensure service plans included a signature documenting agreement on the services for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01640		

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01640	Continued From page 48 The findings include: NO SERVICE PLAN R1 R1 was admitted for assisted living services on September 30, 2022. R1's diagnoses included spastic tetraplegia (spinal cord injury), neurogenic bowel and bladder (a condition that affects control due to damage to the brain, spinal cord, or nerves), and left heel ulcer and cellulitis. On November 18, 2024, at 1:05 p.m., R1 was observed sitting in a wheelchair at the dining room table, while unlicensed personnel (ULP)-C prepared his lunch. R1's Assisted Living Resident Care Plan, dated September 30, 2024, indicated R1 required assistance with dressing and obtaining clothing, bathing, toileting, transferring, range of motion, and housekeeping. Also included, R1 was at risk for falls related to self transfers, was independent with bed mobility, and used bedrails for mobility and positioning, and used the device to help with achieving proper body position, balance, and/or alignment. R1's record lacked a Service Plan. On November 19, 2024, at 1:11 p.m., licensed assistant living director (LALD)-B stated R1 never returned the signed service agreement. LALD-B stated R1 had a new guardian and would sign the necessary paperwork. NO SIGNED SERVICE PLAN R2	01640		

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01640	Continued From page 49 R2 was admitted for assisted living services on September 21, 2018. R2's diagnoses included mood disorder, history of stroke, memory loss, disorientation, and chronic pain. On November 19, 2024, 10:15 a.m., the surveyor observed as ULP-C assisted R2 in his wheelchair, into the garage. ULP-C stated R2 was going out to the garage to smoke. R2's Service Plan (Waiver) - Addendum to Contract, dated November 6, 2024, unsigned, indicated R2 received services including morning and evening cares, activity assistance, ambulation assistance, bathing assistance, behavior monitoring, continence care, medication administration, safety checks, transferring, and "Smoke break" seven times daily. R3 R3 was admitted for assisted living services on December 1, 2018. R3's diagnoses included schizophrenia. On November 18, 2024, at 12:34 p.m., the surveyor observed R3 sitting in a recliner in the living room, watching television and eating a donut and milk. R3's Service Plan (Waiver) - Addendum to Contract, dated October 12, 2021, unsigned, indicated R3 received services including socialization, activity assistance, morning and evening cares, assistance with meals, bathing assistance, behavior management, grooming, medication administration and medication set up.	01640		

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01640	Continued From page 50 On November 20, 2024, at 12:56 p.m., LALD-B stated, "If they don't send it [paperwork] back, I just let it be." LALD-B stated the resident always received a copy of the service plan but stated she didn't follow up to ensure a signature documenting agreement on the services. The licensee's Service Plan/Nursing policy, dated August 1, 2021, indicated all residents receiving assisted living services will have a service plan in place. Within 14 days after the date that services were first provided to a resident, the licensee would finalize a written service plan. Also, the policy indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 51 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required, for one of one resident (R4) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4's diagnoses included schizoaffective disorder (mental health condition), depression, anxiety, bipolar, and Parkinson's disease. R4 began receiving services on November 30, 2020, and was discharged on October 14, 2022. R4's progress notes, dated August 31, 2022, indicated R4 was transferred to the hospital due to agitation and behaviors. On October 19, 2022, R4 was presented a termination notice while still in the hospital, due to the licensee's inability to	01910		

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01910	Continued From page 52 meet R4's needs. R4's record lacked a discharge summary. On November 20, 2024, at 1:06 p.m., clinical nurse supervisor (CNS)-A provided R4's Drug Disposal, dated March 20, 2023, which included five medications, with the dosage, route, and the amount remaining. The document lacked documentation of the prescription number, to whom the medications were given, and names of staff and other individuals involved in the disposition. CNS-A stated the document was missing the required information. The licensee's Medication Disposal policy, dated August 1, 2021, indicated the facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract, and must document in the resident's record the disposition of the medication, including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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GOLDEN POND CRYSTAL	3648 COLORADO AVENUE NORTH CRYSTAL, MN 55422

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02310	Continued From page 53 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 and medical, or nursing standards for one of one resident (R1) with a hospital bedrail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, at 2:55 p.m., the surveyor and clinical nurse supervisor (CNS)-A entered R1's room with R1's permission. R1 was sitting in a manual wheelchair at a table, using an electronic device. R1 had a hospital bed positioned against the wall, with bilateral bedrails in the raised position, affixed to the upper half of the bed frame. The bedrails had eight vertical bars and with nine open areas, and both bedrails were loose, being able to freely move from side to side when grasped. R1 stated he used the bedrails to turn from side to side when in bed and to assist when sitting up on the edge of the bed. R1's diagnoses included spastic tetraplegia (spinal cord injury), neurogenic bowel and bladder (a condition that affects control due to damage to the brain, spinal cord, or nerves), and left heel	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33571	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CRYSTAL	3648 COLORADO AVENUE NORTH CRYSTAL, MN 55422

(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
02310	Continued From page 54 ulcer and cellulitis. R1's record lacked a Service Plan. R1's Assisted Living Resident Care Plan, dated September 30, 2024, indicated R1 required assistance with dressing and obtaining clothing, bathing, toileting, transferring, range of motion, and housekeeping. Also included, R1 was at risk for falls related to self transfers, was independent with bed mobility, and used bedrails for mobility and positioning, and used the device to help with achieving proper body position, balance, and/or alignment. R1's Master Care Plan, dated August 20, 2024, indicated R1 had high risk for falls, had impulsive behavior, needed help with transfers, needed help to sit up and noted R1 may use the side rails to get up. Also indicated, R1 used bedrails for positioning and repositioning. R1's Resident Assessment Form, identified as 90 day assessment, dated August 31, 2024, indicated R1 was "WCC Bound [wheelchair]" and Equipment Observation noted R1's bedrails were appropriate for mobility, with no concerns, and hospital bed, with no concerns. R1's Bed Safety, printed November 20, 2024, indicated R1 could make his needs known, and may use the bedrails to get up and sometimes calls for assistance. The assessment indicated R1 had a hospital bed with bilateral upper bedrails for positioning and repositioning, and to assist with cares in bed, and noted the bedrails were appropriate based upon assessed need, and indicated R1 was educated and informed of the risks of using bedrails. The electronic assessment had spaces to fill in measurements	02310		

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	33571	A. BUILDING: _____ B. WING _____	11/20/2024

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02310	Continued From page 55 for bed safety zones; however, these were blank. R1's record lacked a comprehensive assessment to include evidence of physical inspection of the bedrail and mattress for areas of entrapment and stability of the device, which included actual measurements of the entrapment zones. On November 19, 2024, at 2:59 p.m., clinical nurse supervisor (CNS)-A stated she had not comprehensively assessed the bedrails to include measurements when the hospital bed was received for R1. CNS-A stated she had recently obtained a bedrail assessment form from a colleague and planned to implement it; however, during the survey, CNS-A was able to locate an assessment in the electronic medical for the use of bedrails. CNS-A stated she would call the durable medical equipment company to have the bedrails tightened. The licensee's Side Rails (bedrails) policy, dated August 1, 2021, included, when the licensee was aware a resident was utilizing bedrails on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of bedrails, and verify that the bedrail in use was of a safe design and utilized consistent with the manufacturer's directions, and noted the policy would be followed regardless of who owned or supplied the bedrail. The policy indicated, when the bedrails were in use, the registered nurse must conduct an assessment to identify the intended purpose of the bedrail and the risks regarding the use of the bedrail, and would determine if the bedrail was considered to be safe by ensuring the bedrail was consistent with manufacturer's directions, were installed securely and maintained in good operating condition, and	02310		

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	33571	A. BUILDING: _____ B. WING _____	11/20/2024

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02310	Continued From page 56 the bedrail design was consistent with the Food and Drug administration's 2006 recommended dimensional measurements to reduce entrapment. This meant the bedrail zones 1, 2, and 3 must not exceed 4.75 inches. Also, the resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of bedrails. Education provided would be documented in the resident record. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. 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." No further information was provided.	02310		

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02310	Continued From page 57 TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *11/18/24*
Time: 12:00:00
Report: 1051241179

Food and Beverage Establishment Inspection Report

Location:
Golden Pond Crystal
3648 Colorado Avenue North
Crystal, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0038313
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635371785
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION, THERE IS NO CFPM POSTED. ERANEL COMPLETED HIS TRAINING CLASS AND NEEDS TO SUBMIT THE RESULTS WITH THE ONLINE STATE APPLICATION. LINK WILL BE PROVIDED WITH REPORT.

Comply By: 11/25/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, LOANN DEGAGNE.

DISCUSSED THE FOLLOWING WITH STAFF, ERANEL:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE
CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE
REPORTABLE ILLNESSES & SYMPTOMS

Type: Full
Date: *11/18/24*
Time: 12:00:00
Report: 1051241179
Golden Pond Crystal

Food and Beverage Establishment Inspection Report

THE KITCHEN HAS VINYL WOODEN FLOORS, SMOOTH TEXTURE CEILING, GRANITE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, AND A NSF 184 DISHWASHER.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241179 of 11/18/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Eranel Polonio

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us