



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 18, 2025

Licensee

Golden Hearts Home Care Services LLC

3940 Ninth Lane

Anoka, MN 55303

RE: Project Number(s) SL34747015

Dear Licensee:

On March 20, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 20, 2024, and the follow-up survey completed on December 12, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 20, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 20, 2024, found not corrected at the time of the March 20, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on March 20, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on March 20, 2025, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze". The ink is dark and the signature is fluid.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/20/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3940 NINTH LANE ANOKA, MN 55303		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL34747015-2 On March 20, 2025, the Minnesota Department of Health conducted a second follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 20, 2024, and a follow-up survey completed December 18, 2024. At the time of the survey, there were five residents; all receiving services under the provider's Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement documented action taken in response to correction orders issued from a revisit survey completed on December 18, 2024. This had the potential to affect all residents and staff of the licensee. 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	0 340			

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0 340	Continued From page 2 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 March 20, 2025, a follow-up visit was conducted related to the licensing orders reissued on the December 18, 2024, revisit survey. During the onsite visit on March 20, 2025, at 10:00 a.m., a plan of correction dated March 4, 2025, was provided to the surveyor. The plan of correction outlined the licensing orders issued on the December 18, 2024 survey with action plans identifying how each violation was corrected. Review of the plan of correction indicated the correction plan was not implemented as noted by the licensee's plan of correction, and the following order was re-issued: 1290 On March 25, 2025, at 11:23 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee failed to implement the documented plan of correction for the background study issues identified on the initial survey on September 20, 2024, and the revisit survey on December 18, 2024. CNS/LALD-A stated she assumed office administrator (OA)-L implemented affiliation of an employee to the licensee's health facility identification (HFID) number when the employee began working at the facility, per the plan of correction; however, stated, "[OA-L] never did it." No further information provided.	0 340			
{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 3 (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,	{0 480}			

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{0 480}	Continued From page 4 existing floor, wall, and ceiling finishes are 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:	{0 480}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

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{0 650}	Continued From page 5 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	{0 800}	Not reviewed during this survey.		

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{0 800}	Continued From page 6 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:	{0 800}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	{0 810}			

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{01290}	Continued From page 8 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-M) had a cleared background study affiliated with the assisted living license as required. This had the potential to affect the licensee's current 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: During the onsite visit on March 20, 2025, at 9:53 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A provided a plan of correction dated March 4, 2025, which outlined the licensing orders issued on the December 18, 2024 revisit survey with action plans identifying how each violation was corrected. The plan indicated background studies would be	{01290}			

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{01290}	Continued From page 9 completed for all employees and the CNS would provide proof of background studies to effectively meet the duties as the licensing entity of the licensee. The plan also indicated CNS would be responsible for monitoring compliance and noted all of the actions had been corrected. The surveyor requested CNS/LALD-A provide the NETStudy 2.0 roster for this facility. On March 20, 2025, at 10:25 a.m., CNS/LALD-A provided an employee list that listed ULP-M as a current employee, hired March 6, 2023, to provide direct assisted living services to the licensee's residents. The licensee's "March Anoka House 2025" staff schedule indicated ULP-M worked March 8, 2025, and March 15, 2025, from 7:00 p.m. to 7:00 a.m., and was scheduled to work March 22, 2025, and March 29, 2025, from 7:00 p.m. to 7:00 a.m. ULP-M's employee record contained a background study, dated October 7, 2023, affiliated with another license number operated under the same ownership umbrella as the licensee (health facility identification (HFID) number 36085). ULP-M's employee record lacked evidence the licensee had a cleared and eligible background study for the licensee's assisted living facility (HFID 34747). On March 20, 2025, at 11:09 a.m., CNS/LALD-A provided the NETStudy 2.0 roster, dated March 20, 2025. ULP-M was listed on the roster, indicating affiliation date as March 20, 2025, and indicated determination was "In Process." A person search in NETStudy 2.0 roster for ULP-M indicated ULP-M was affiliated with the licensee's HFID number on March 20, 2025, at 10:59 a.m.	{01290}			

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{01290}	Continued From page 10 During an interview on March 20, 2025, at 11:23 a.m., CNS/LALD-A stated ULP-M worked in another facility owned by the licensee and stated ULP-M had "worked a few Saturday nights," at this facility to help with open shifts. CNS/LALD-A stated she had informed office administrator (OA)-L when ULP-M began working at this facility and directed OA-L to affiliate ULP-M with this facility's HFID number. CNS/LALD-A stated she unaware that this had not happened. At 11:45 a.m., CNS/LALD-A stated, "[OA-L] never did it," and stated OA-L submitted the affiliation after the surveyor requested the NETStudy 2.0 roster. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated under the employment process includes the following: "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -The director or designee is responsible for initiating the criminal background study for new employees -NETStudy 2.0 (or current version) will be used for the background check -The employee will be directed to locations established by DHS to obtain fingerprint scans -Employees will be instructed that photographic identification will be required -Employees/study subjects may enter their own background study demographic information using the facility identification code provided -Results of the background study will be maintained in the employee's personnel file." No further information was provided.	{01290}			

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{01760}	Continued From page 11	{01760}	Not reviewed during this survey.		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates	{01790}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01790}	Continued From page 12 and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must	{01790}			

Minnesota Department of Health

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{01790}	Continued From page 13 document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}			
{02430} SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept	{02430}			

Minnesota Department of Health

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{02430}	Continued From page 15 private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by:	{02430}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 7, 2025

Licensee

Golden Hearts Home Care Services LLC

3940 Ninth Lane

Anoka, MN 55303

RE: Project Number(s) SL34747015

Dear Licensee:

On December 18, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 20, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 20, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 20, 2024, found not corrected at the time of the December 18, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

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

1290-Background Studies Required-144g.60 Subdivision 1 - \$3,000.00

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - 500.00

The details of the violations noted at the time of this follow-up survey completed on December 18, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 18, 2024, we identified the following violation(s):

2320-Appropriate Care And Services-144g.91 Subd. 4 (b)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$7,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

You are encouraged to retain this document for your records. It is your responsibility to share the

information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a horizontal line extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/18/2024
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34747015-1 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 20, 2024. At the time of the survey, there were six (6) residents; six receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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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:	{0 480}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 3 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of one employee (unlicensed personnel (ULP)-B).	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 4 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: The facility TB risk assessment was completed June 2024, and indicated the facility was at a low risk for TB transmission. On December 16, 2024, between 10:15 a.m., and 1:15 p.m., the surveyor observed ULP-B provide meals and other various tasks to multiple residents. ULP-B was hired on March 12, 2024, to provide assisted living services to licensee's residents. On December 16, 2024, at approximately 11:30 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A provided the surveyor a binder which included documentation of corrections made for the prior survey. The surveyor observed a chest x-ray (CXR) completed for ULP-B on October 11, 2024. The surveyor asked CNS/ALD-A if ULP-B had completed a two-step Tuberculin Skin Test (TST) or blood test (TB Gold) prior to completing the CXR. CNS-ALD-A explained that ULP-B had always tested positive for TB when completing a TST or TB Gold test, so ULP-B just provided her with a CXR instead. CNS/ALD-A was unaware if a TST or TB Gold test was performed prior to the CXR, so she summoned ULP-B to inquire	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 5 whether any other test was completed. ULP-B checked her electronic health record and showed the surveyor a positive TB Gold test that was completed October 11, 2024. The licensee failed to obtain and include all required documentation for ULP-B's employee record. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) last updated on December 13, 2024, indicated "A CXR alone is not acceptable documentation. You either need -documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay test (IGRA), and -a CXR with provider evaluation after that date Or -documentation of refusal of both the two-test TST and IGRA -followed by a new CXR and provider evaluation." The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated if staff provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. If staff with a verbal, but undocumented, history of previous positive TST or blood test, will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use. No further information provided.	{0 660}			

Minnesota Department of Health

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{0 780}	Continued From page 6	{ 0 780}			
{ 0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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	{ 0 780}			

Minnesota Department of Health

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{ 0 780}	Continued From page 7 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 12:06 p.m., surveyor toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: 1. A smoke alarm was not installed in occupied resident bedroom 1. 2. A smoke alarm was not installed outside bedroom 1 in the immediate vicinity of this bedroom. During the facility tour and interview at 12:06 p.m. on December 16, 2024, CNS/ALD-A verified the above listed observations while accompanying on the tour.	{ 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	{0 800}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3940 NINTH LANE ANOKA, MN 55303		
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{0 800}	Continued From page 8 by:	{0 800}	Not reviewed during this survey		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	{0 810}			

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{0 810}	Continued From page 9 This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey		
{ 0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure facility elements and smoking material disposal did not constitute a distinct hazard to life. This had the potential to directly affect all 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 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).	{ 0 820}			

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{ 0 820}	Continued From page 10 The findings include: On December 16, 2024, at 12:06 p.m., surveyor toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: 1. A key only deadbolt lock was installed above the door knob on the front door. An exit sign was posted above the front door and this door was labeled as an exit on the posted floor plan. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Rear door which was marked as an emergency exit was obstructed by storage of items including a wheelchair, a folding closet door, and three boxes of supplies. During the facility tour on December 16, 2024, CNS/ALD-A, verified the non-compliant locking arrangement on the front exit door and impeded egress on rear exit door. CNS/ALD-A stated that a maintenance person was contacted about the unapproved/non-compliant lock, but no progress had been made towards rectifying the issue. 2. Burnt cigarettes were disposed of improperly in the following locations: - Burnt cigarettes were disposed of on the floor and in a plastic garbage can near a table where lighter fluid was stored. - Burnt cigarettes were disposed of in an open ashtray. - Dozens of burnt cigarette butts were disposed of on the rear deck and steps. - Dozens of burnt cigarette butts were disposed of on the ground around the wood deck. - On the ground in the backyard where gasoline	{ 0 820}			

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{ 0 820}	Continued From page 11 cans and gasoline-powered outdoor equipment were stored. - Inside the shed with wood floor, wall, and ceiling surfaces; and where gasoline cans were stored. Burnt cigarette butts were disposed of onto the floor, in a pile of sawdust, and onto wooden shelves and working surfaces, leaving scorch marks. - In a trash can with a plastic liner that contained paper towels and wood scraps. - On top of plastic sheeting on the ground outside the shed. Improper disposal of smoking materials creates a fire hazard. During the facility tour and interview at 12:06 p.m., on December 16, 2024, CNS/ALD-A verified burnt cigarettes were improperly disposed of in the garage, on the deck, in the shed, and in the backyard. CNS/ALD-A explained there was a designated smoking area at the front of the facility where a container was kept for smoking material disposal. CNS/ALD-A demonstrated that an approved smoking material disposal receptacle was provided on the rear porch, but acknowledged the quantity of cigarette butts improperly disposed of in and around the facility.	{ 0 820}			
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	{0 830}			

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{0 830}	Continued From page 12	{0 830}			
{01290} SS=I	This MN Requirement is not met as evidenced by: 144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D) had a cleared background study with the assisted living license as required. This had the potential to affect the licensee's six current residents. 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	{01290}	Not reviewed during this survey		

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{01290}	Continued From page 13 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 December 16, 2024, at approximately 11:30 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A provided the surveyor a binder which included corrective action plan for ULP-D's background study. The plan indicated a background check was completed for ULP-D on September 17, 2024, with fingerprints due by October 1, 2024. It also indicated the administrator would ensure completion of fingerprints and monthly employee file audits would be initiated to ensure full compliance with background study requirements. On December 16, at 5:27 p.m., by email, clinical nurse supervisor/assisted living director (CNS/ALD)-A provided an employee list that listed ULP-D as a current employee. ULP-D was hired on February 13, 2020, under the licensee's comprehensive home care license then on August 1, 2021, began providing assisted living services to licensee's residents. ULP-D's employee record contained a background study dated February 12, 2020, for the closed comprehensive home care license (health facility identification (HFID) number 33463). ULP-D's employee record lacked evidence the licensee had a cleared and eligible background study for their assisted living facility (HFID	{01290}			

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{01290}	Continued From page 14 34747). The licensee's "December 2024" staff schedule indicated ULP-D worked every week on Wednesdays and Thursdays from 7:00 p.m. to 7:00 a.m. On December 17, 2024, at 11:08 a.m., the surveyor requested ULP-D's background study clearance and CNS/ALD-A stated ULP-D completed her finger printing and was going to look into why the licensee did not receive the clearance yet. On December 17, 2024, at 11:48 a.m., the surveyor was provided a NetStudy Roster 2.0 which ULP-D was not listed. The NetStudy 2.0 showed ULP-D was affiliated to licensee on September 17, 2024, but separated from licensee on October 2, 2024. On December 18, 2024, at 1:13 p.m., administrator (A)-E stated she was responsible for completing background study and stated ULP-D was told to get fingerprinted on October 1, 2024. Once completed, A-E was notified by ULP-D the fingerprinting was completed. A-E stated since ULP-D was a longtime employee, she did not give her the procedures sheet that lists out what the ULP needed to do such as signing the "consent/disclosure form," which allowed the licensee to receive the results of the fingerprinting. A-E explained since the disclosure form was not signed by ULP-D, she was disqualified. A-E also explained the procedure was sufficient but not followed. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated under the employment process includes the following: "The	{01290}			

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{01290}	Continued From page 15 Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -The director or designee is responsible for initiating the criminal background study for new employees -NetStudy 2.0 (or current version) will be used for the background check -The employee will be directed to locations established by DHS to obtain fingerprint scans -Employees will be instructed that photographic identification will be required -Employees/study subjects may enter their own background study demographic information using the facility identification code provided -Results of the background study will be maintained in the employee's personnel file." No further information was provided.	{01290}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	{01760}			

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{01760}	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration were documented accurately in the medication administration record (MAR) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A explained she communicated to staff about changes in resident condition, medications, treatments, etc. by going to the facility to inform staff working and would contact staff by phone if they were not working. On December 16, 2024, at 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-F pull out a container from a cabinet containing R1's blood glucometer (checks blood sugar using blood) and two insulin pens. ULP-F also pulled out a bubble pack which contained R1's medication for each time slot. ULP-F applied a clean needle to R1's Novolog FlexPen (fast acting insulin) and primed the needle by wasting two units (standard procedure to remove air within the needle) and replaced the cap. ULP-F assisted R1	{01760}			

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{01760}	Continued From page 17 with checking his blood glucose using the glucometer and the result was 245. During this time, the surveyor was only able to observe on the electronic medication administration record (eMAR) the directions to administer divalproex 500 milligrams (mg) (treats seizures)-one tablet three times a day. Without looking at the eMAR, ULP-F dialed 28 units on the Novolog FlexPen and gave it to R1 to self-inject. Prior to injecting himself, R1 asked ULP-F if the dose was correct, then asked "are you sure it is not 26 or 27?" ULP-F chuckled and did not respond. R1 injected the insulin and gave the insulin pen back to ULP-F. ULP-F then opened the bubble pack containing the medications for R1's noon dose (on the label it stated 1-divalproex 500 mg, and 2-felbalmate 400 mg) and poured the three pills into a small metal medication cup and handed them to R1 to administer. The surveyor did not observe ULP-F look at the eMAR prior to administering the insulin and oral medications to verify the correct dose, route, time, medication, and right resident. The surveyor asked ULP-F how he determined how much insulin to dial up, he said had the scheduled and sliding scale (additional insulin given based on blood glucose results) memorized, but agreed he should have checked the eMAR prior to administering the medications. ULP-F then proceeded to document the oral and insulin administration on the eMAR as given. R1's diagnoses included type 1 diabetes mellitus (body does not make insulin to bring blood glucose levels down) with ketoacidosis (serious complication of diabetes) without coma, seizure disorder, and oppositional defiant disorder (frequent and ongoing pattern of anger, irritability, arguing and defiance toward parents and other authority figures).	{01760}			

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{01760}	Continued From page 18 R1's service agreement dated June 16, 2023, indicated R1 received medication administration and treatment services (blood sugar checks). R1's physician order dated October 11, 2024, identified an order for scheduled Novolog with meals and Novolog sliding scale: -Novolog 12 units with breakfast; -Novolog 26 units with lunch; and -Novolog 28 units with dinner (at 9:00 p.m. when R1 eats dinner) -Sliding scale -inject 0-10 units based on blood glucose (BG): BG below 200, give 0 units; BG 201-250, give 2 units; BG 251-300, give 4 units; BG 301-350, give 6 units; BG 351-400, give 8 units; and BG 401-450, give 10 units. R1's eMAR dated December 1-16, 2024, read: insulin aspart (Novolog) (Daily) -Novolog 12 units with breakfast; -Novolog 26 units with lunch; -Novolog 28 units with dinner; and -Inject 0-10 Units based on BG via sliding scale with meals at 8:00 a.m., 12:00 p.m., and 9:00 p.m. BG below 200, give 0 units BG 201-250, give 2 units BG 251-300, give 4 units BG 301-350, give 6 units BG 351-400, give 8 units BG 401-450, give 10 units and call house registered nurse (RN). R1's medical record included the following information for Novolog administration: -December 4, 2024, at 9:00 p.m., BG 106,	{01760}			

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{01760}	Continued From page 19 unlicensed personnel (ULP)-D initialed and circled initials on eMAR, note indicated "Novolog not administered." -December 5, 2024, at 12:00 p.m., BG 380, ULP-F initialed and circled initials on eMAR, note indicated 34 units of Novolog given (26 scheduled + 8 sliding scale). -December 9, 2024, at 12:00 p.m., BG 279, unknown amount of sliding scale Novolog given, ULP-J documented "done" and "given." -December 10, 2024, at 12:00 p.m., BG 101, ULP-F initialed and circled initials for scheduled Novolog. Note indicated "no corrective insulin given." -December 13, 2024, at 8:00 a.m., BG 132 or 136 (documented in two different areas), ULP-H initialed and circled initials. Progress notes indicated "no novolog [sic] insulin administered," and eMAR note indicated "BG was 136 hence to [sic] low to be administered." -December 14, 2024, at 12:00 p.m., BG 232, ULP-K documented 26 units of Novolog given, but should have received 28 units per eMAR. On December 18, 2024, at 2:28 p.m., the surveyor left ULP-H a voicemail. The surveyor was unable to interview ULP-H for clarification on whether Novolog was given on December 13, 2024, at 8:00 a.m. On December 18, 2024, at 2:47 p.m., ULP-I explained she was trained to hold scheduled Novolog when the "blood sugar was very low," and when asked was considered very low, she stated below 70. ULP-I explained she would give the scheduled Novolog if the BG was between 70-100 and if above 200, she would add the sliding scale to the scheduled dose. ULP-I stated it was confusing how to document the scheduled and sliding scale since they were together on the	{01760}			

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{01760}	Continued From page 20 eMAR. On December 18, 2024, at 3:02 p.m. and 4:20 p.m., CNS/ALD-A stated she trained staff to hold the scheduled Novolog when it was "really low, below 70." She explained when the staff initials are circled on the eMAR, it meant the medication was not given. CNS/ALD-A stated it would be best to separate the scheduled Novolog from the sliding scale Novolog for The licensee's corrective plan dated September 20, 2024, indicated ULP- F, ULP-J, ULP-K, and ULP-I attended re-education on blood glucose monitoring and insulin administration. The National Institutes of Health (NIH)'s article titled Incorrect Insulin Administration: A Problem that Warrants Attention dated January 2016, indicated incorrect administration of insulin (too little, too much, or at the wrong times) could result in serious and life-threatening events such as hypoglycemia (low blood sugar causing shaking, weakness, sweating, chills, increased heart rate, dizziness, seizures, coma, and/or death), hyperglycemia (high blood sugar causing thirst, headaches, blurred vision, fatigue, fruity-smelling breath, confusion, coma, and/or death), and diabetic ketoacidosis (a life-threatening complication of high blood sugar that occurs when the body does not have enough insulin to process blood sugar resulting in blood acids called ketones building up in the blood to dangerous levels). The licensee's Supervision: Unlicensed policy effective date August 1, 2021, indicated the unlicensed personnel providing services to assisted living residents will be supervised to assure that the work is being performed	{01760}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 21 competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to residents of licensee. No further information provided.	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	{01790}			

Minnesota Department of Health

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{01790}	Continued From page 22 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	{01880}	Not reviewed during this survey.		

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{01880}	Continued From page 23 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	{01940}			

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{01940}	Continued From page 24		{01940}	Not reviewed during this survey.	
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication administration process was completed as instructed by one of one employee (unlicensed personnel (ULP)-F). 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: On December 16, 2024, at 12:05 p.m., the surveyor observed ULP-F pull out a container from a cabinet containing R1's blood glucometer		02320		

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02320	Continued From page 25 (checks blood sugar using blood) and two insulin pens. ULP-F also pulled out a bubble pack which contained R1's medication for each time slot. ULP-F applied a clean needle to R1's Novolog FlexPen (fast acting insulin) and primed the needle by wasting two units (standard procedure to remove air within the needle) and replaced the cap. ULP-F assisted R1 with checking his blood glucose using the glucometer and the result was 245. During this time, the surveyor was only able to observe on the electronic medication administration record (eMAR) the directions to administer divalproex 500 milligrams (mg) (treats seizures)-one tablet three times a day. Without looking at the eMAR, ULP-F dialed 28 units on the Novolog FlexPen and gave it to R1 to self-inject. Prior to injecting himself, R1 asked ULP-F if the dose was correct, then asked "are you sure it is not 26 or 27?" ULP-F chuckled and did not respond. R1 injected the insulin and gave the insulin pen back to ULP-F. ULP-F then opened the bubble pack containing the medications for R1's noon dose (on the label it stated 1-divalproex 500 mg, and 2-felbalmate 400 mg) and poured the three pills into a small metal medication cup and handed them to R1 to administer. The surveyor did not observe ULP-F look at the eMAR prior to administering the insulin and oral medications to verify the correct dose, route, time, medication, and right resident. The surveyor asked ULP-F how he determined how much insulin to dial up, he said had the scheduled and sliding scale (additional insulin given based on blood glucose results) memorized, but agreed he should have checked the eMAR prior to administering the medications. ULP-F then proceeded to document the oral and insulin administration on the eMAR as given. R1's eMAR dated December 1-16, 2024, read the	02320			

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02320	Continued From page 26 following: -Novolog insulin-inject 26 units at lunch plus the sliding scale (SS) based on blood sugar numbers; -Novolog give 2 units if blood glucose is between 201-250 (for a total of 28 units given); -divalproex 500 mg-one tablet by mouth three times per day; and -felbamate 400 mg-two tablets by mouth three times per day (treats seizures). The licensee's blood sugar checks/insulin administration education document dated September 20, 2024, indicated all staff were re-educated on blood glucose monitoring and insulin administration. Also, staff were re-educated on the "5 rights" of medication administration (the right resident, the right drug, right time, the right dose, and the right route. The document read ULP-F attended this re-education. ULP-F's employee record included: - skills/competency test of administration of oral medication, card/bubble pack administration, insulin administration, and blood glucose testing completed September 10, 2024. -insulin administration-on-line training completed on September 11, 2024, and September 13, 2024. On December 18, 2024, at 4:20 p.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated staff have been trained to always check the eMAR, click "verify" and check to make sure there are the correct number of pills from the bubble pack. The licensee's Medication Administration policy dated August 1, 2021, noted unlicensed personnel that will provide assistance with medication administration would be trained and	02320			

Minnesota Department of Health

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02320	Continued From page 27 competency tested by the registered nurse. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: -purpose -dosage -route -frequency -instructions related to the medication and specific to the residents, as appropriate, -side effects -resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
{02430} SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by:	{02430}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2024

Licensee
Golden Hearts Home Care Services LLC
3940 Ninth Lane
Anoka, MN 55303

RE: Project Number(s) SL34747015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL34747015-0 On September 16, 2024, through September 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility license. On September 17, 2024, an immediate correction order was issued for tag identification number 1290. During the survey, the licensee took action to mitigate the immediate risk of the order. Noncompliance remained, and the scope and level remain unchanged. On September 19, 2024, an immediate correction order was issued for tag identification number 2310. During the survey, the licensee took action to mitigate the immediate risk of the order. Noncompliance remained, and the scope and level remain unchanged.	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 480 SS=F	On September 20, 2024, an immediate correction order was issued for tag identification number 1760. 144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 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	0 480			

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0 480	Continued From page 2 to the FBEIR for any compliance dates.	0 480			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

Minnesota Department of Health

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0 650	Continued From page 3 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: On September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A provided an undated employee list that read ULP-B was hired March 12, 2024. On September 17, 2024, at 11:10 a.m., program coordinator (PC)-C stated ULP-B was hired on September 24, 2023, to work at a different facility and began working at this facility on March 12, 2024. On September 16, 2024, through September 18, 2024, the surveyor observed ULP-B provide medication management including insulin administration, meals, and other various tasks to all residents. ULP-B's record lacked documented evidence of: - competency in insulin administration, and - competency in inhaler administration. On September 17, 2024, at 12:18 p.m., ULP-B stated she was not confident whether a nurse observed her on insulin administration but believed she was. She stated the first facility she worked at did not require insulin administration. On September 18, 2024, at 2:08 p.m., CNS/ALD-A stated ULP-B's employee record was	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3940 NINTH LANE ANOKA, MN 55303		
(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
0 650	Continued From page 4 stolen on June 20, 2024, while it was stored at the other facility, so training and competencies were missing but were performed. The licensee's Personnel Records policy dated August 1, 2022, noted the personnel record for each staff member would include competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program	0 660			

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0 660	Continued From page 5 based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed June 2024, and indicated the facility was at a low risk for TB transmission. On September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A provide an undated employee list that read ULP-B was hired March 12, 2024. On September 17, 2024, at 11:10 a.m., program coordinator (PC)-C stated ULP-B was hired on September 24, 2023, to work at a different facility and began working at this facility on March 12, 2024. On September 16, 2024, through September 18, 2024, the surveyor observed ULP-B provide medication management, meals, and other various tasks to all residents. ULP-B's record included Baseline TB Screening Tool for Healthcare Workers (HCWs) dated September 24, 2023, and a chest x-ray (CXR)	0 660			

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0 660	Continued From page 6 completed on October 4, 2023. ULP-B's employee record lacked documentation of refusal of both the two-step tuberculin skin test (TST) and interferon-gamma release assays (IGRAs), followed by CXR accompanied by provider evaluation. On September 17, 2024, at 11:45 a.m., PC-C stated she did not have a copy of the positive TST to go with ULP-B's CXR. She stated ULP-B had a bad reaction to the TST and ULP-B could explain further. On September 17, 2024, at 11:52 a.m., ULP-B stated about 19 or 20 years ago, she had a TST which the result of the test was inconclusive so "they" (person reading the test) thought she had a reaction to the test or that she was in contact with TB. Since then, she completed CXRs. ULP-B does not recall if she received the TB vaccine. On September 17, 2024, at 12:09 p.m., PC-C stated she was not aware the provider's evaluation was required with the CXR, and she would obtain that going forward. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) last updated on April 3, 2024, indicated "A CXR alone is not acceptable documentation. You either need -documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay test (IGRA), and -a CXR with provider evaluation after that date Or -documentation of refusal of both the two-test TST and IGRA -followed by a new CXR and provider evaluation."	0 660			

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0 660	Continued From page 7 The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated if staff provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. If staff with a verbal, but undocumented, history of previous positive TST or blood test, will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 780 SS=E	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	0 780			

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0 780	Continued From page 8 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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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). The findings include: On September 18, 2024, at 10:00 a.m., survey staff toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: 1. A smoke alarm was not installed in occupied resident bedroom 1. 2. A smoke alarm was not installed outside bedroom 1 in the immediate vicinity of this bedroom.	0 780			

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0 780	Continued From page 9 During the facility tour interview on September 18, 2024, CNS/ALD-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	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). The findings include:	0 800			

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0 800	Continued From page 10 On September 18, 2024, at 10:00 a.m., survey staff toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: RESIDENT BEDROOMS 1. The window well cover obstructed the egress window in occupied resident bedroom 6. The window well cover prevented the egress window from opening. When window well covers are installed, the covering must be removable without the use of tools or special knowledge of the window well area by the building occupants and must not interfere with the opening of the window in any way. 2. The screen for the egress window was obstructed by trim installed around the window in occupied resident bedroom 6. The screen was difficult to remove. Trim used around egress windows must not interfere with the removal of the screen or obstruct window hardware required to open the window. 3. A refrigerator was plugged into a power strip in occupied resident bedroom 2. 4. Two extension cords were daisy chained together in occupied resident bedroom 4. 5. The cover was missing on one electrical wall outlet and the ceiling light fixture cover was cracked in occupied resident bedroom 5. INTERIOR 1. An exit sign was posted above the door leading from the facility into the attached garage. This door was labeled as an exit on the floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 2. In the attached garage, a freezer was plugged	0 800			

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0 800	Continued From page 11 into a multiplug adapter which was daisy chained to a red extension cord. A second freezer was plugged into a power strip, which was daisy chained to the multiplug adapter with the red extension cord. 3. An exit sign was posted at the back door and the door opening was obstructed by the storage of items on the exterior steps for the door. This door was also labeled as an exit on the posted floor plan. Improper storage outside an exit door could delay exiting the building in the event of an emergency. 4. A flexible plastic vent was used for the clothes dryer in the laundry room, creating a fire hazard. 5. Main floor resident bathroom labeled as #2: - The toilet handle was loose. - Water drained very slowly from the sink. - The wall surface was unfinished next to the sink. 6. In the main floor resident bathroom labeled as #1, the towel bar was missing from the brackets installed on the wall. 7. In the basement resident bathroom, the shower door handle was loose and one screw was missing from the handle. 8. The cover for the light fixture was missing at the base of the stairs in the basement. 9. There was a hole in the wall under the light switch in the basement living room. 10. The bottom door closer was disconnected from the sunroom door leading out to the deck. EXTERIOR 1. An extension cord was plugged into an exterior wall outlet on the facility with the cord buried under the ground. This extension cord surfaced in the shed and was plugged into a power strip with two daisy chained extension cords. These extension cords ran under the shed door and out to the exterior. Extension cords must not be used	0 800			

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0 800	Continued From page 12 as a substitute for permanent wiring. Improper use of extension cords and power strips creates a fire hazard. 2. Broken fluorescent tube lights were stored on the ground on the side of the facility. 3. The backyard was used for storage of resident personal items. During the facility tour interview on September 18, 2024, CNS/ALD-A, verified the above listed 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 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810			

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0 810	Continued From page 13 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide required training and 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 September 18, 2024, clinical nurse supervisor/assisted living director (CNS/ALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The resident sleeping room numbers were not identified on the FSEP floor plan in the emergency evacuation exits floor plan binder.	0 810			

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0 810	Continued From page 14 On September 18, 2024, at 10:00 a.m., survey staff toured the facility with CNS/ALD-A. During the tour, the surveyor observed an identifier was not posted on or adjacent to the resident's sleeping room door verbally identified as 5 by CNS/ALD-A. During the facility tour interview on September 18, 2024, CNS/ALD-A verified a room identifier was not posted for resident sleeping room 5. Resident sleeping room identifiers are required to be posted and included on the fire safety and evacuation floor plan. The identifiers installed on the resident sleeping room doors must correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. On September 18, 2024, at 10:00 a.m., survey staff toured the facility with CNS/ALD-A. During the tour, the surveyor observed two fire extinguishers installed in the facility, one in the living room on the main floor and one in the basement. The main floor FSEP floor plan labeled one fire extinguisher in the kitchen. The main floor fire extinguisher location was not accurately identified in the FSEP. The basement fire extinguisher was not identified on the FSEP floor plan. The licensee failed to develop and maintain a FSEP evident by a record review of the available documentation. The FSEP included an emergency disaster plan for fire in an assisted living facility which inappropriately directed the building occupants to generally plan to shelter in place during a fire. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these actions in the plan. The employee actions were limited to the RACE (Rescue, Alarm,	0 810			

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0 810	Continued From page 15 Contain, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. Record review of the available documentation indicated the licensee did not include specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. These procedures were not included in the binder where the FSEP was located. During an interview on September 18, 2024, at 1:00 p.m., CNS/ALD-A verified the FSEP required revision. CNS/ALD-A stated evacuation procedures for individualized needs of the residents had been created and these reports would be emailed to the surveyor by the end of the day. CNS/ALD-A verified these resident evacuation reports were not included in the binder where the FSEP was located. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year. During an interview on September 18, 2024, at 1:00 p.m., CNS/ALD-A stated these training records would be emailed to the surveyor by the end of the day. On September 18, 2024, at 7:12 p.m., CNS/ALD-A emailed an employee FSEP training record for ten employees. Three employees did not complete FSEP training twice per year. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year. No resident training records for fire safety and evacuation were provided. During an interview on September 18, 2024, at 1:00 p.m., CNS/ALD-A stated residents participated in the facility fire drills and no additional training had been completed.	0 810			

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0 810	Continued From page 16 DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of completed fire drill reports lacking the required frequency. During an interview on September 18, 2024, at 1:00 p.m., CNS/ALD-A stated these drill records would be emailed to the surveyor by the end of the day. On September 19, 2024, at 9:08 p.m., CNS/ALD-A emailed seven fire drill reports recorded during the last year. All of these fire drills were completed during the 7 a.m. to 7 p.m. shift. Fire drills were not conducted during the 7 p.m. to 7 a.m. shift. Some of the fire drill reports did not include the last names of the employees who participated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820			

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0 820	Continued From page 17 by: Based on observation and interview, the licensee failed to ensure facility elements and smoking material disposal did not constitute a distinct hazard to life. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 18, 2024, at 10:00 a.m., survey staff toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: 1. A key only deadbolt lock was installed above the door knob on the front door. An exit sign was posted above the front door and this door was labeled as an exit on the posted floor plan. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the facility tour interview on August 18, 2024, CNS/ALD-A, verified the non-compliant locking arrangement on the exit door. 2. Burnt cigarettes were disposed of improperly in the following locations: Inside the facility: One burnt cigarette was located on top of a dresser in occupied resident bedroom 4. Attached garage:	0 820			

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0 820	Continued From page 18 - Burnt cigarettes were disposed of on the floor and in a plastic garbage can near a table where lighter fluid was stored. - Four burnt cigarettes were disposed of in an open ashtray. Backyard and exterior of the facility: - On the floor surface of the attached wood deck where an open container of lighter fluid was stored. - On a metal chair sitting on the attached wood deck. - On the ground around the wood deck. - On the ground in the backyard where gasoline cans and gasoline-powered outdoor equipment were stored. - Inside the shed with wood floor, wall, and ceiling surfaces; and where gasoline cans were stored. - In a trash can with a plastic liner that contained paper towels and wood scraps. - On top of plastic sheeting on the ground outside the shed. Improper disposal of smoking materials creates a fire hazard. During the facility tour interview, on September 18, 2024, CNS/ALD-A verified burnt cigarettes were improperly disposed of in the garage, on the deck, in the shed, and in the backyard. CNS/ALD-A explained there was a designated smoking area at the front of the facility where a container was kept for smoking material disposal. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for	0 830			

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0 830	Continued From page 19 fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for installation of egress windows in resident bedrooms and obtain a building permit for an outdoor accessory structure. 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). The findings include: On September 18, 2024, at 10:00 a.m., survey staff toured the facility with clinical nurse supervisor/assisted living director (CNS/ALD)-A. During the tour, the surveyor observed the following: 1. New egress windows had been installed in resident bedrooms. During the facility tour interview on September 18, 2024, CNS/ALD-A stated bedroom windows had been replaced last month. CNS/ALD-A stated a permit from the city was obtained but they were not aware a plan review application needed to be submitted to Minnesota Department of Health Engineering Services for the project. 2. A lean-to attached to a shed was located next to the backyard fence. During the facility tour	0 830			

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0 830	Continued From page 20 interview on September 18, 2024, CNS/ALD-A stated a resident had constructed the lean-to on Monday and verified a permit was not obtained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D) had a cleared background study with the assisted living license as required. This had the potential to affect the licensee's six current residents. This resulted in issuance of an immediate correction order on September 17, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290			

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01290	Continued From page 21 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 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 September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A provided an employee list that listed ULP-D as a current employee. ULP-D was hired on February 13, 2020, under the licensee's comprehensive home care license then on August 1, 2021, began providing assisted living services to licensee's residents. ULP-D's employee record contained a background study dated February 12, 2020, for the closed comprehensive home care license (health facility identification (HFID) number 33463). ULP-D's employee record lacked evidence the licensee had a cleared and eligible background study for their assisted living facility (HFID 34747). The licensee's "September [licensee name] 2024" staff schedule indicated ULP-D worked every week on Wednesdays and Thursdays from 7:00 p.m. to 7:00 a.m. On September 17, 2024, at 9:02 a.m., the licensee provided a NetStudy Roster 2.0 which ULP-D was not listed.	01290			

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01290	Continued From page 22 On September 17, 2024, at 9:23 a.m., CNS/ALD-A stated ULP-D worked every Wednesday and Thursdays and was currently on the schedule and worked alone on the overnight shift. CNS/ALD-A then showed the surveyor documentation ULP-D completed recently on a resident's progress notes. On September 17, 2024, at 10:39 a.m., administrator (A)-E stated during the license change from comprehensive home care to assisted living, she completed the background studies on everyone, but ULP-D must have been missed. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated under the employment process includes the following: "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -The director or designee is responsible for initiating the criminal background study for new employees -NetStudy 2.0 (or current version) will be used for the background check -The employee will be directed to locations established by DHS to obtain fingerprint scans -Employees will be instructed that photographic identification will be required -Employees/study subjects may enter their own background study demographic information using the facility identification code provided -Results of the background study will be maintained in the employee's personnel file." No further information was provided.	01290			

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01290	Continued From page 23 TIME PERIOD FOR CORRECTION: IMMEDIATE During the survey, the licensee took action to mitigate the immediate risk of the order. Noncompliance remained, and the scope and level remain unchanged.	01290			
01760 SS=I	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) receiving medication management services. This resulted in issuance of an immediate correction order on September 20, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	01760			

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01760	Continued From page 24 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 September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A explained she communicated to staff about changes in resident condition, medications, treatments, etc. by going to the facility to inform staff working and would contact staff by phone if they were not working. On September 17, 2024, at 9:55 a.m., unlicensed personnel (ULP)-B set up the blood glucose (BG) monitor by placing a new strip into the glucometer machine (reads blood glucose by blood). ULP-B gave R1 the device that pricks his finger which he poked his finger and squeezed blood out and placed the glucometer up to the blood to get absorbed into the machine. R1 said it did not work, so ULP-B placed a new strip into the machine and R1 then obtained more blood from the same finger. The blood glucose result was 283 milligrams per deciliter (mg/dL) (an average blood glucose is between 80-130 mg/dL for a diabetic person). ULP-B set up R1's oral medications by opening the bubble pack, poured the medications from a bubble pack into a metal medication cup then opened another medication in a foil package containing one tablet and placed it in the same metal cup and gave them to R1. ULP-B dialed R1's Levemir FlexPen insulin (long-acting insulin to treat Type 1 and 2 diabetes) to 42 units and R1 placed the needle on the FlexPen and injected himself in the abdomen.	01760			

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01760	Continued From page 25 ULP-B then picked up the Novolog FlexPen insulin (fast acting) and noted the FlexPen had seven (7) units remaining, so she gave R1 that FlexPen and he placed a needle and injected himself in the abdomen. ULP-B then grabbed a brand new Novolog FlexPen and dialed it to 4 units and R1 completed the same process. The surveyor did not observe any of the FlexPens get primed (process of putting the needle on the FlexPen and setting it to two units and wasting it before dialing the prescribed dose). The surveyor then observed on the electronic medication administration record (eMAR) the Novolog sliding scale indicated if the blood glucose was between 251-300 mg/dL, give four (4) units of insulin. ULP-B should have only given 4 units not 11 units of Novolog. At the end of medication administration at 10:20 a.m., ULP-B went over the "5 rights" of medication administration to confirm her understanding on what to look for while comparing the medication to the eMAR (right person, right medication, right dose, right route, and right time). INSULIN ADMINISTRATION ERROR R1's diagnoses included type 1 diabetes mellitus (body does not make insulin to bring blood glucose levels down) with ketoacidosis (serious complication of diabetes) without coma, seizure disorder, and oppositional defiant disorder (frequent and ongoing pattern of anger, irritability, arguing and defiance toward parents and other authority figures). R1's service agreement dated June 16, 2023, indicated R1 received medication administration and treatment services (BG checks). R1's physician order dated August 19, 2024, identified an order for Novolog sliding scale with	01760			

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01760	Continued From page 26 meals: BG below 200, give 0 units BG 201-250, give 2 units BG 251-300, give 4 units BG 301-350, give 6 units BG 351-400, give 8 units BG 401-450, give 10 units and call MD R1's MAR dated September 1-16, 2024, read: "insulin aspart (NOVOLOG) (Daily) 100 unit/ml [milliliters] Inject 0-10 Units based on BG via sliding scale with meals at 8:00 a.m., 12:00 p.m., and 9:00 p.m. BG below 200, give 0 units BG 201-250, give 2 units BG 251-300, give 4 units BG 301-350, give 6 units BG 351-400, give 8 units BG 401-450, give 10 units and call MD." R1's medical record also included the following information related to Novolog insulin administration documentation for September 2024: -11 documented refusals/denials of Novolog insulin; -22 out of 48 times ULPs marked Novolog insulin as administered/taken/done but amount of insulin given was not documented; -September 2, 2024, at 8:00 a.m., 10 units administered (4 units should have been given per sliding scale); -September 2, 2024, at 12:00 p.m., 12 units administered (the maximum amount of insulin to administer per the order is 10 units; -September 3, 2024, at 8:00 a.m., 12 units administered (the maximum amount of insulin to administer per the order is 10 units); -September 4, 2024, at 8:00 a.m., 20 units	01760			

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01760	Continued From page 27 administered (the maximum amount of insulin to administer per the order is 10 units); -September 4, 2024, at 9:00 p.m., 10 units administered (0 units should have been given per sliding scale); -September 5, 2024, at 5:30 p.m., 16 units administered (the maximum amount of insulin to administer per the order is 10 units); -September 5, 2024, at 9:00 p.m., 10 units administered (0 units should have been given per sliding scale); -September 6, 2024, at 8:00 a.m., 18 units administered (the maximum amount of insulin to administer per the order is 10 units); -September 6, 2024, at 12:00 p.m., 16 units administered (the maximum amount of insulin to administer per the order is 10 units); -September 9, 2024, at 12:00 p.m., 20 units administered (the maximum amount of insulin to administer per the order is 10 units); -September 12, 2024, at 12:00 p.m., 14 units administered (the maximum amount of insulin to administer per the order is 10 units); and -September 13, 2024, at 8:00 a.m., 16 units administered (the maximum amount of insulin to administer per the order is 10 units). On September 17, 2024, at 2:48 p.m., during interview with CNS/ALD-A and ULP-B, ULP-B told CNS/ALD-A she gave 14 units (the surveyor observed ULP-B give 11 units of Novolog) because she misread the MAR thinking she needed to give 10 units of Novolog plus sliding scale Novolog (an order for Humalog 10 units scheduled at breakfast was discontinued on August 19, 2024). On September 18, 2024, at 1:37 p.m., CNS/ALD-A stated every week on Sundays, she checked for medication compliance and stated	01760			

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01760	Continued From page 28 she must have missed the errors regarding staff giving additional insulin on top of the sliding scale. On September 20, 2024, at 10:22 a.m., CNS/ALD-A could not answer why staff were not documenting the number of units of Novolog insulin given. She stated she kept reminding staff to document it in the "notes" section of the BG task or in the progress notes. NON-IMMEDIATE ORAL ADMINISTRATION ERROR On September 17, 2024, at approximately 10:00 a.m., after R1 received insulin and oral medications as stated above, the surveyor asked ULP-B to look for levocarnitine 330 mg tablet (treats carnitine deficiency) on the eMAR and asked ULP-B how many tablets R1 was supposed to receive. ULP-B realized R1 was supposed to receive three tablets, not one. She did not know he was supposed to get three tablets twice a day because she read it as one tablet three times a day. R1 stated he normally received three tablets of levocarnitine at each scheduled time. R1's prescriber order dated June 24, 2024, ordered levocarnitine 330 mg tablets-three tablets by mouth twice a day. R1's eMAR dated September 2024, read levocarnitine 330 mg tablet, give three tablets by mouth twice a day at 8:00 a.m. and 8:00 p.m. On September 17, 2024, at 1:35 p.m., the surveyor explained to CNS/ALD-A that only one tablet of levocarnitine was given instead of three tablets. CNS/ALD-A asked if ULP-B was nervous and stated ULP-B had given R1 his medications in the past as she gave it "on and off."	01760			

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01760	Continued From page 29 ULP-B's oral medication administration competency dated October 8, 2023, indicated CNS/ALD-A deemed ULP-B competent to administer oral medications. The National Institutes of Health (NIH) ' s article titled Incorrect Insulin Administration: A Problem that Warrants Attention, dated January 2016, indicated incorrect administration of insulin (too little, too much, or at the wrong times) could result in serious and life-threatening events such as hypoglycemia (low blood sugar causing shaking, weakness, sweating, chills, increased heart rate, dizziness, seizures, coma, and/or death), hyperglycemia (high blood sugar causing thirst, headaches, blurred vision, fatigue, fruity-smelling breath, confusion, coma, and/or death), and diabetic ketoacidosis (a life-threatening complication of high blood sugar that occurs when the body does not have enough insulin to process blood sugar resulting in blood acids called ketones building up in the blood to dangerous levels). The licensee's Supervision: Unlicensed policy effective date August 1, 2021, indicated the unlicensed personnel providing services to assisted living residents will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to residents of licensee. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01790	Continued From page 30	01790			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790			

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NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3940 NINTH LANE ANOKA, MN 55303		
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01790	Continued From page 31 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	01790			

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01790	Continued From page 32 affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:25 a.m., during entrance conference, clinical nurse supervisor/assisted living director (CNS/ALD)-A stated the licensee provided medication management services for all of licensee's residents. On September 18, 2024, at 9:00 a.m., ULP-B explained what she would do to set up the medications for a leave of absence and how to document it, but stated the written procedures were unavailable. On September 18, 2024, at 2:10 p.m., CNS/ALD-A stated they had written procedures for unplanned times away, but it was not located at the facility. CNS/ALD-A then showed the surveyor the medication management plan for residents away from home policy and asked if that was sufficient. The surveyor showed CNS/ALD-A the required information that needed to be available to staff within the policy. The procedures were not provided by the end of the survey. The licensee's Medication Management Plan for Residents Away from Home policy, effective August 1, 2021, indicated the RN had developed written procedures/protocols for the ULPs, including special instructions regarding controlled substances, including: - the type of container(s) to be used for the medications appropriate to the facility's medication system; - how the container(s) should be labeled; - written information about the medications to be	01790			

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01790	Continued From page 33 provided; - documentation requirements including date medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and any other information; - how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or the designated representative; and -medications may be set up for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored according to manufacturer's guidelines for injectable medications and only authorized personnel had access. This had the potential to affect all residents residing in the facility, staff, and visitors.	01880			

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01880	Continued From page 34 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: MONITORING TEMPERATURE On September 17, 2024, at 8:40 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A unlocked the medication refrigerator located near the staff desk and medication storage area within the facility's living room. CNS/ALD-A stated they did not monitor the refrigerator temperature and could not ensure the temperature remained within the manufacturer's guidelines; however, she would get a thermometer so they could start monitoring the temperature. The content of the refrigerator included: -Levemir (insulin detemir) FlexPen 100 unit/milliliter (ml) (3 ml) subcutaneous - 35 unopened FlexPens for diabetes; -Novolog (insulin aspart) FlexPen 100 unit/ml (3 ml) subcutaneous - two FlexPens for diabetes; -diazepam 5 milligram (mg)/ 1 ml (30 ml) solution - two unused bottles used for seizures; and -Mounjaro (tirzepatide) injection 15 mg/0.5 ml - three pens for weekly injection for diabetes. The manufacturer's instructions for Levemir revised December 2022, read Levemir FlexPen should be stored unused between 36 to 46 degrees Fahrenheit (F). Do not freeze. The manufacturer's instructions for Novolog	01880			

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01880	Continued From page 35 revised February 2023, read Novolog FlexPen should be stored unused between 36-46 degrees F. Do not freeze. The manufacturer's instructions for Mounjaro revised May 2024, read Mounjaro pen should be stored between 36-46 degrees F. Do not freeze. The manufacturer's instructions for diazepam revised September 2024, read diazepam should be stored at room temperature around 77 degress F. UNSECURED PILL On September 17, 2024, at 8:50 a.m., after reviewing the contents of the medication refrigerator, the surveyor located a small white round pill labeled 8P/136 found on the floor next to the leg of the desk. The pill was benztropine mesylate 0.5 mg used in the treatment of Parkinson's Disease (movement disorder of the nervous system that worsen over time) and/or used to treat Parkinson-like symptoms caused by using certain medications. CNS/ALD-A did not know how long that pill had been there and was not notified the pill was missing. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated when [facility name] was providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. The policy also indicated medications requiring refrigeration are stored in an enclosed container or area separated from foods. Temperature was maintained at 35-40 degrees.	01880			

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01880	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940			

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01940	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) receiving blood glucose (BG) monitoring. 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: During the entrance conference on September 16, 2024, at 10:25 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated the licensee provided treatment management services to residents, including blood glucose monitoring. R1's diagnoses included type 1 diabetes mellitus (body does not make insulin to bring blood glucose levels down) with ketoacidosis (serious complication of diabetes) without coma, seizure disorder, and oppositional defiant disorder (frequent and ongoing pattern of anger, irritability, arguing and defiance toward parents and other authority figures). R1's service agreement dated June 16, 2023, indicated R1 received medication administration	01940			

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01940	Continued From page 38 and treatment services (BG checks). R1's Individualized Treatment and Therapy Plan (ITTP) dated April 3, 2024, indicated to staff to contact the registered nurse (RN) if the blood glucose was less than 70 milligrams per deciliter (mg/dL) or greater than 300 mg/dL (an average blood glucose is between 80-130 mg/dL for a diabetic person). On the same ITTP it also read, "If Blood Sugar is above 300 notify RN or call 911). R1's physician order dated August 19, 2024, and electronic medication administration record (EMAR) dated September 2024, read the following: Novolog (lowers blood glucose) sliding scale with meals: BG below 200, give 0 units BG 201-250, give 2 units BG 251-300, give 4 units BG 301-350, give 6 units BG 351-400, give 8 units BG 401-450, give 10 units and call MD. The information provided to staff indicated to call the MD, RN, or call 911 if the BG was out of range, which was unclear who to contact. On September 17, 2024, at 9:55 a.m., unlicensed personnel (ULP)-B set up the BG monitor by placing a new strip into the glucometer machine (reads blood glucose by blood). ULP-B gave R1 the device that pricks his finger which he poked his finger and squeezed blood out and placed the glucometer up to the blood to get absorbed into the machine. R1 said it did not work, so ULP-B placed a new strip into the machine and R1 then attempted to obtain more blood from the same finger. The blood glucose result was 283 mg/dL and set up Novolog insulin for R1 to inject himself	01940			

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01940	Continued From page 39 with. On September 18, 2024, at 9:00 a.m., ULP-B assisted R1 with checking his BG. The result was 437 mg/dL and administered the correct amount of insulin ordered. The surveyor was unaware if ULP-B notified CNS/ALD-A of the high BG. R1's treatment management plan lacked clear procedures for notifying a registered nurse or other when a problem arose with treatments or therapy services. On September 20, 2024, at 10:22 a.m., CNS/ALD-A stated ULPs would document BG results in R1's progress notes, and when the BG was high, they would text or call her and she tracked the results for R1's next MD visit. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the following: The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: -Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 40 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R2) who a utilized consumer bed rail. This resulted in issuance of an immediate correction order on September 19, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 September 19, 2024, at 1:40 p.m., the surveyor and clinical nurse supervisor/assisted living director (CNS/ALD)-A observed a consumer style bed rail on the upper right side adjacent to the headboard of R2's bed. R2's bed rail was observed to be snug because it was wedged at the corner of the headboard and the side piece which kept it from moving around. The bed rail did not attach to the bed with any type of strap. The bed rail was measured approximately 20 inches wide and 16 to 20 inches tall and had	02310			

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02310	Continued From page 41 3-foot poles that extended under the mattress. The bed rail was tubular wrapped in a white tape like material. R2 was admitted on February 17, 2022, and diagnoses included neuropathy (nerve pain), chronic pain syndrome, and anxiety. R2 service plan signed February 17, 2022, indicated services included assistance with walking, bathing, dressing and grooming, meals, manage anxiety, wheelchair use, and medication management. R2's Risk Agreement-Bed Rails completed on February 15, 2022, included the following: -purpose and intention of the bed rail; -risk vs. benefits discussion; -documentation of observations of zones 1 through 4 (zones of entrapment measured for hospital bed rails, not consumer bed rails). R2's record lacked: -Reassessment of bed rail every 90 days, and as needed with a change in condition; -Documentation of use, installation, and maintenance according to manufacturer's guidelines; -Documentation the Consumer Product Safety Commission (CSPC) website was reviewed regularly for recalls; and -Documentation of physical inspection of bed rails/mattresses for areas of entrapment, stability, and correct installation. On September 19, 2024, at 1:31 p.m., CNS/ALD-A stated R2 moved in with the consumer bed rail and it did not come with any product information. CNS/ALD-A stated when she assisted R2 with showers and made her bed, she	02310			

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02310	Continued From page 42 would check to make sure it wasn't "shaky." She also said R2 could verbalize to CNS/ALD-A if there were any issues or concerns as well. She was unaware of the requirement to check for recalls on the CPSC website. The surveyor and CNS/ALD-A went on the CPSC website with the bed rail information (Bed Handles, model BA10W) and found R2's bed rail had been recalled on May 20, 2014. This discovery was then shared with R2. On September 19, 2024, at 2:20 p.m., CNS/ALD-A stated she was unaware of the documentation requirements and did not know it needed to be completed quarterly. She stated she completed the assessment upon admission only. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) Assisted Living Resources and Frequently-Asked Questions (FAQs) website dated April 3, 2024, indicated the following documentation should be included in a resident's record related to consumer bed rails: -CPSC website should be reviewed regularly for	02310			

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02310	Continued From page 43 updates on portable bed rail recalls; -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's Side Rail Use policy dated August 1, 2021, indicated before implementing bed rails for a resident, the registered nurse (RN) will conduct a bed rail assessment. The RN will document the purpose of the bed rails and the education provided, document the discussion of risks and benefits of using bed rails, and that the RN is responsible to ensure that the bed rails in use are of a safe design and properly maintained. The policy also indicated the bed rail will be used consistent with the manufacturer's recommendations, and the need for bed rails will be reassessed and documented as needed but not less than every 90 days. The policy did not include information about checking for recalls. No further information provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk of the order.	02310			

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02310	Continued From page 44 Noncompliance remained, and the scope and level remain unchanged.	02310			
02430 SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal health and medical information was kept private for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included type 1 diabetes mellitus (body does not make insulin to bring blood glucose levels down) with ketoacidosis (serious complication of diabetes) without coma, seizure	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3940 NINTH LANE ANOKA, MN 55303		
(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
02430	Continued From page 45 disorder, and oppositional defiant disorder (frequent and ongoing pattern of anger, irritability, arguing and defiance toward parents and other authority figures). R1's service agreement dated June 16, 2023, indicated R1 received services to include medication administration and blood glucose monitoring. R1's service plan dated November 6, 2023, indicated R1 received services to include medication administration. From September 16, 2024, through September 18, 2024, unlicensed personnel (ULP)-B wore large black wireless headphones placed over one ear and the other behind the ear throughout the shifts. The surveyor was unable to determine if she was utilizing the headphones or not. On September 18, 2024, at 9:00 a.m., during R1's blood glucose monitoring and medication administration, the surveyor observed the headphones on one ear and the other placed behind her ear and ULP-B's phone was on the desk lit up showing what appeared to be on a phone call with someone named "Big A." The phone showed the Bluetooth was activated on that call and the red button was present to end the call. The mute button on the screen did not appear to be activated as it was the same color as the background. The surveyor did not observe ULP-B speaking to anyone but R1 during the task. Throughout the task with R1, medications, and blood glucose results were discussed verbally. On September 18, 2024, at 3:15 p.m., clinical nurse supervisor/assisted living director	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2024
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02430	Continued From page 46 (CNS/ALD)-A stated staff should not be on the phone while performing resident services and mentioned that ULP-B had been wearing headphones but did not know why. CNS/ALD-A also stated she had even "signed a form." CNS/ALD-A then called ULP-B into the same room and asked her if she had been using the phone during resident cares. ULP-B stated she either listened to music or "apps [applications]" but during cares, she would turn it down or pause it. ULP-B stated what the surveyor observed on her phone was an actual "app" and that she was not on the phone with anyone. The licensee's Resident Confidentially policy dated August 1, 2022, indicated resident information is not discussed with anyone except those involved with providing care or service to the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			

Type: Full
Date: 09/16/24
Time: 11:55:21
Report: 1029241321

Food and Beverage Establishment Inspection Report

Page 1

Location:

Golden Hearts Home Care Servic
3940 9th Lane
Anoka, MN55303
Anoka County, 02

Establishment Info:

ID #: 0037854
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7635283891
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS ITEMS IN REFRIGERATOR IN DANGER ZONE. ITEMS DISCARDED BY REP. COOLER ADJUSTED. REP INSTRUCTED TO VERIFY SAFE TEMPS PRIOR TO PLACING MORE TCS ITEMS INTO COOLER. TEMP CONTROL SOLUTIONS DISCUSSED.

Comply By: 09/16/24

4-300 Equipment Numbers and Capacities

4-302.12B

**** Priority 2 ****

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

NO SMALL DIAMETER PROBE THERMOMETER. EXAMPLE PROVIDED. REP INSTRUCTED TO OBTAIN SMALL DIAMETER PROBE THERMOMETER.

Comply By: 09/16/24

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERMAL STICKERS OR MIN/MAX THERMOMETER NOT PRESENT. MAINTAIN METHOD TO TEST DISHWASHER HIGH TEMP AT FACILITY. THERMAL STICKER PROVIDED DURING INSPECTION TO VERIFY DISHWASHER HIGH TEMP.

Comply By: 09/16/24

Food and Equipment Temperatures

Type: Full
Date: 09/16/24
Time: 11:55:21
Report: 1029241321
Golden Hearts Home Care Servic

Food and Beverage Establishment
Inspection Report

Process/Item: COLD HOLD/INTERNAL THERMO
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: No

Process/Item: COLD HOLD/BUTTER
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/MILK
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR - CAVITY
Violation Issued: No

Process/Item: COLD HOLD/BEANS
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR - CAVITY
Violation Issued: Yes

Process/Item: COLD HOLD/SOUR CREAM
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: No

Process/Item: COLD HOLD/SHRED CHEESE
Temperature: 48 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/CREAM OF WHEAT
Temperature: 63 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/MILK
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR 2
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	4	3

Establishment residential in nature with wood floors, wood/composite-wood cabinetry and drawers, laminate countertops, tile backsplash, smooth painted walls, and popcorn ceiling. Establishment uses dishwasher with a high temp sanitizer setting to sanitize equipment and utensils.

Type: Full
Date: 09/16/24
Time: 11:55:21
Report: 1029241321
Golden Hearts Home Care Servic

Food and Beverage Establishment
Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241321 of 09/16/24.

Certified Food Protection Manager;JOSEPHINE M. BALL

Certification Number: FM110616 Expires: 03/31/25

Inspection report reviewed with person in charge and emailed.

Signed: JOSEPHINE BALL
RN

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241321

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

2

Date

09/16/24

No. of Repeat RF/PHI Categories Out

0

Time In

11:55:21

Legal Authority MN Rules Chapter 4626

Time Out

Golden Hearts Home Care Servic

Address

3940 9th Lane

City/State

Anoka, MN

Zip Code

55303

Telephone

7635283891

License/Permit #

0037854

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUTPIC knowledgeable; duties & oversight

2

IN

OUT N/ACertified food protection manager, duties

Employee Health

3

IN

OUTMgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygenic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT N/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood obtained from approved source

12

IN

OUT N/A

N/O

Food received at proper temperature

13

IN

OUTFood in good condition, safe, & unadulterated

14

IN

OUT

N/A

 N/ONequired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT N/A N/OFood separated and protected

16

IN

OUT N/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT N/A

N/O

Proper cooking time & temperature

19

IN

OUT N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

 N/OProper hot holding temperatures

22

IN

OUT N/AFood proper cold holding temperatures

23

IN

OUT N/A N/OProper date marking & disposition

24

IN

OUT

N/A

 N/OTime as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT N/AFood Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUTToxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

IN

OUTWater & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

IN

OUTProper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

 N/OPlant food properly cooked for hot holding

35

IN

OUT N/A

N/O

Approved thawing methods used

36

IN

XThermometers provided & accurate

Food Identification

37

IN

OUTFood properly labled; original container

Prevention of Food Contamination

38

IN

OUTInsects, rodents, & animals not present

39

IN

OUTContamination prevented during food prep, storage & display

40

IN

OUTPersonal cleanliness

41

IN

OUTWiping cloths: properly used & stored

42

IN

OUTWashing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

IN

OUTIn-use utensils: properly stored

44

IN

OUTUtensils, equipment & linens: properly stored, dried, & handled

45

IN

OUTSingle-use/single service articles: properly stored & used

46

IN

OUTGloves used properly

Utensil Equipment and Vending

47

IN

OUTFood & non-food contact surfaces cleanable, properly designed, constructed, & used

48

IN

XWarewashing facilities: installed, maintained, & used; test strips

49

IN

OUTNon-food contact surfaces clean

Physical Facilities

50

IN

OUTHot & cold water available; adequate pressure

51

IN

OUTPlumbing installed; proper backflow devices

52

IN

OUTSewage & waste water properly disposed

53

IN

XToilet facilities: properly constructed, supplied, & cleaned

54

IN

XGarbage & refuse properly disposed; facilities maintained

55

IN

OUTPhysical facilities installed, maintained, & clean

56

IN

OUTAdequate ventilation & lighting; designated areas used

57

IN

OUTCompliance with MCIAA

58

IN

OUTCompliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Inspector (Signature)

Trevor McCliment

Date:

09/17/24