



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 29, 2024

Licensee

Golden Touch Health Care LLC
8216 Hampshire Court North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35842015

Dear Licensee:

On January 30, 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 November 1, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 1, 2023 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 November 1, 2023, found not corrected at the time of the January 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4) - \$500.00

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on January 30, 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.

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 within the time period 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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:

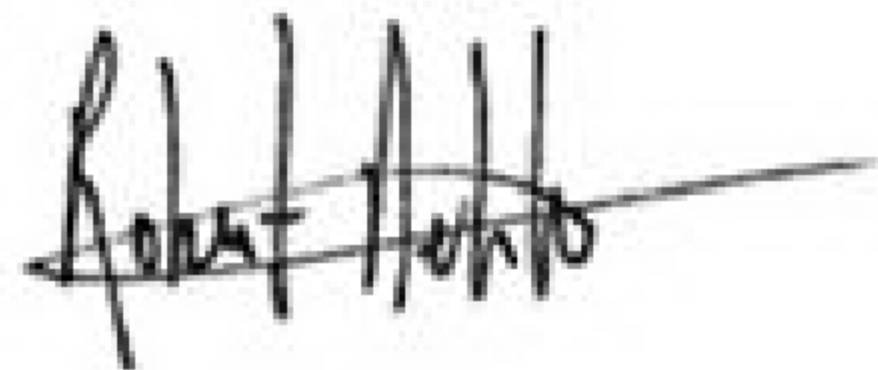
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Bob Dehler at 651-201-3710.

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 "Robert Dehler", with a long horizontal stroke extending to the right.

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/30/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL35842015-1 On January 23, 2024, through January 30, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 1, 2023. At the time of the survey, there were 03 residents; 03 receiving services services license. As a result of the revisit, the following orders were reissued.	{0 000}			
{0 230} SS=C	144G.18 NOTIFICATION OF CHANGES IN INFORMATION A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, paragraph (a), clause (1), (3), (4), (17), or (18). This MN Requirement is not met as evidenced by: No further action required.	{0 230}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action required.	{0 460}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			

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{0 550}	Continued From page 2	{0 550}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}			
{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;	{0 650}			

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{0 650}	Continued From page 3 (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: No further action required.	{0 650}			
{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}			

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{0 660}	Continued From page 4 No further action required.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}			
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	{0 730}			

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{0 730}	Continued From page 5 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	{0 730}			

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{0 730}	Continued From page 6 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required.	{0 730}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the potential to affect all staff, residents, 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	{0 800}			

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{0 800}	Continued From page 7 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 23, 2024, at 11:30 a.m. survey staff toured the facility with unlicensed personnel (ULP)-B. It was observed that bedroom #1 had been significantly damaged. Every wall in the room had a hole kicked or punched into it. Some of the larger holes spanned from wall stud to wall stud and from the floor to halfway up the wall. The insulation and vapor barrier inside the exterior walls were exposed to the bedroom and in some locations damaged or removed. It was observed that bedroom #1 had significantly soiled carpet throughout the space. Not only was the carpet covered with dust and debris from the wall damage, but it was also covered with cigarette butts, garbage, and heavy staining. It was observed that bedroom #1 had the closet doors removed, and damage done to the wood trim and walls of the closet. Half of the wood trim for the closet was missing leaving broken drywall and nails exposed to the room. Large gouges had been taken out of the corners of the walls forming the closet leaving the unfinished construction materials exposed to the room. It was observed that the carpet throughout the facility was heavily soiled. Wear patterns could be seen through the hallways, stairs, and other common areas. It was observed that the carpet had been	{0 800}			

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{0 800}	Continued From page 8 removed from the stairs leading into the lower level leaving the unfinished treads exposed. The stair treads and risers had large gaps at the joints. There were no stair nosings on the treads to prevent someone's toe from catching on the open joint and causing a fall. Carpet tacks could still be seen and felt at the top stair landing and on the sides of some of the stair treads. ULP-B visually verified these deficient findings at the time of discovery. During interview on January 30, 2024, at 12:30 p.m. licensed assisted living director (LALD)-E stated bedroom #1 was no longer used as a bedroom. He referenced a regulatory requirement from the department of human services (DHS) and stated he had reduced his capacity from 5 residents to 4 residents in order to remove bedroom #1 from his assisted living license and be in compliance with the DHS requirement. Survey staff explained to LALD-E that the room still needed to be cleaned and repaired even if it wasn't used as a bedroom anymore. LALD-E stated he understood the deficiency. No further information was provided. 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;	{0 810}			

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{0 810}	Continued From page 9 (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 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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	{0 810}			

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{0 810}	Continued From page 10 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 January 25, 2024, licensed assisted living director (LALD)-E 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 licensee's FSEP, titled "Fire Emergency", undated, failed to include the following: The FSEP included standard employee procedures but 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. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	{0 810}			

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{0 810}	Continued From page 11 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on January 30, 2024, at 12:30 p.m., LALD-E stated he had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. No further information was provided.	{0 810}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 910}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/30/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
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{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
{01290} SS=F	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: No further action required.	{01290}			

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{01370}	Continued From page 13	{01370}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}			

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{01370}	Continued From page 14 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}			
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required.	{01380}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	{01500}			

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{01500}	Continued From page 15 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	{01500}			

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{01500}	Continued From page 16 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	{01530}			

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{01530}	Continued From page 17 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}			

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{01620}	Continued From page 18 This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}			
{01940} SS=F	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	{01940}			

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{01940}	Continued From page 19 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. This MN Requirement is not met as evidenced by: No further action required.	{01940}			
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other	{01970}			

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{01970}	Continued From page 20 information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action required.	{01970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 28, 2023

Licensee

Golden Touch Health Care LLC
8216 Hampshire Court North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35842015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

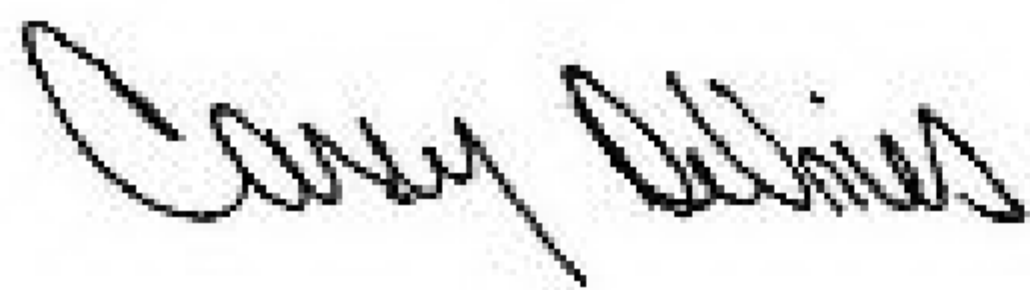
To submit a reconsideration request, please visit:

<https://www.web.health.state.mn.us/form/HRD-Appeals-Form>

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries".

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2023
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35842015-0 On October 30, 2023, through November 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 230 SS=C	144G.18 NOTIFICATION OF CHANGES IN INFORMATION A provisional licensee or licensee shall notify the	0 230			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 230	Continued From page 1 commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, paragraph (a), clause (1), (3), (4), (17), or (18). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the commissioner in writing within 60 calendar days after changing their phone number. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 30, 2023, at 8:43 a.m., and 8:49 a.m., the surveyor called the licensee's phone number on record with the Minnesota Department of Health (MDH), but the surveyor received an automated message back that the surveyor reached a construction company and was instructed to press number one or two to speak to certain individuals. The licensee's Application for Assisted Living License dated May 19, 2021, and signed by licensed assisted living director (LALD)-E indicated in page one (1) under the application contact information the same number. The licensee's license renewal application dated	0 230		

Minnesota Department of Health

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0 230	Continued From page 2 May 24, 2022, signed by the LALD-E indicated in page one (1) under applicant information the same number as the contact number for licensee. On October 31, 2023, at 2:33 p.m., when the surveyor presented to LALD-E the licensee's applications LALD-E stated someone at the commissioner's office (MDH) changed their phone number when transcribing. LALD-E gave the surveyor a different number and stated that was their number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 230			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	0 460			

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NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
(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
0 460	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had a potential to affect all licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: On October 30, 2023, at 11:55 a.m., during the entrance conference clinical nurse supervisor (CNS)-A stated licensee did not have a system in place for residents to call for help 24 hours a day, seven days a week. On October 30, 2023, at 12:56 p.m., the surveyor observed no system in place for residents to request staff assistance when needed 24 hours a day, seven days a week. On October 31, 2023, at 2:30 p.m., licensed assisted living director (LALD)-E stated licensee did not have a system in place for residents to request information. LALD-E also stated the residents were alert and independent with activities. No further information was provided.	0 460			

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0 460	Continued From page 4	0 460		
	TIME PERIOD FOR CORRECTION: Seven (7) days			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 30, 2023, 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 5	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550			

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0 550	Continued From page 6 The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On October 30, 2023, at 12:55 p.m., the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the grievance procedure. On October 30, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated licensee thought all posting requirement were met. The licensee's Complaint/Grievance Process policy dated August 1, 2021, indicated residents will be informed of their right to complain to the facility about the services received and of the process to follow when making a complaint to the provider. Residents and their representatives will be informed that complaints may be made without fear of discrimination and/or retaliation. The policy lacked the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 7 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 employee records included all required content for one of two employees (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, 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).	0 650			

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0 650	Continued From page 8 The findings include: ULP-B started employment with licensee November 8, 2022. On October 31, 2023, between 7:45 a.m., and 9:30 a.m., the surveyor observed ULP-B administer medications and prepare breakfast for licensee's residents. ULP-B's record lacked a current job description to include qualification, responsibilities, and identification of staff persons providing supervision. On October 31, 2023, at 3:40 p.m., project manager (PM)-C stated ULP-B's employee record lacked a current job description. In addition, PM-C stated every employee needed to have a currently dated and signed job description. Licensee's Employee Records policy dated August 1, 2021, indicated licensee will keep an employee record for all paid employees. Employee records will be kept up-to-date and confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
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	0 660			

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0 660	Continued From page 9 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 licensee's TB facility risk assessment tool dated August 9, 2022, indicated the licensee had a low risk for TB. The licensee had not updated TB facility risk assessment annually as required.	0 660			

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0 660	Continued From page 10 The Minnesota Department of health's (MDH) Assisted Living Resources & Frequently Asked Questions (FAQs) indicated each provider licensed by MDH is required to complete a TB risk assessment annually. ULP-D started employment with licensee on December 9, 2022. ULP-D's record included a TB history and symptom screening tool dated December 9, 2023, and chest X-ray result dated November 1, 2022. ULP-D's record lacked a two-step Mantoux or TB blood test result with a negative result before doing an X-ray. On October 31, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated ULP-D's record lacked negative TB result. CNS-A also stated all licensee employees should have completed either a two-step Mantoux or TB blood test. The Minnesota Department of health's Assisted Living Resources & Frequently Asked Questions (FAQs) indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, health symptom screening, TB skin testing via the	0 660			

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0 660	Continued From page 11 Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on facility risk assessment or a negative IGRA (blood test) No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all three current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - develop and maintain the EP; - maintain and annual EP updates; - EP program patient population; - process for EP collaboration; - development of EP policies and procedures; - subsistence needs for staff and residents including emergency lighting; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - development of communication plan; - names and contact information of staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;	0 680			

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0 680	Continued From page 13 - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - roles under a wavier declared by secretary; and - emergency prep training program. On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated licensee had reviewed the EPP with engineering surveyor and was aware of the missing content. CNS-A also state licensee will update the EPP to reflect requirement. The licensee's Emergency Management Policy dated August 1, 2021, indicated [licensee] will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730			

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0 730	Continued From page 14 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 730			

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0 730	Continued From page 15 licensee failed to complete a discharge summary for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was discharged from the licensee on January 1, 2023. R3 lacked a discharge summary. On October 31, 2023, at 3:40 p.m., clinical nurse supervisor (CNS)-A stated R3's records lacked a discharge summary. Project manager (PM)-C stated the licensee had transferred R3's records to another location owned by the licensee that burned down. CNS-A also stated the licensee was aware to complete discharge summaries but not when residents were transfered within licensee's facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=F	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	0 780			

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0 780	Continued From page 16 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
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0 780	Continued From page 17 The findings include: On October 30, 2023, from 11:00 a.m. and 12:00 p.m., survey staff toured the facility with the clinical nurse supervisor (CNS)-A and the project manager (PM)-C. It was observed that bedroom #1 did not have a smoke alarm installed. CNS-A and PM-C stated that the resident who used to live in the room had removed it and they were in the process of repairing the room and reinstalling the smoke alarm. These deficient conditions were visually verified by CNS-A and PM-C accompanying on the tour. On October 31, 2023, during a remote interview with the licensed assisted living director (LALD)-E, survey staff was emailed a picture of a newly installed smoke alarm in bedroom #1. 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	0 800			

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0 800	Continued From page 18 failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 30, 2023, from 11:00 a.m. and 12:00 p.m., survey staff toured the facility with the clinical nurse supervisor (CNS)-A and the project manager (PM)-C. It was observed that bedroom #1 had been significantly damaged. Every wall in the room had a hole kicked or punched into it. Some of the larger holes spanned from wall stud to wall stud and from the floor to halfway up the wall. The insulation and vapor barrier inside the exterior walls were exposed to the bedroom and in some locations damaged or removed. It was observed that bedroom #1 had significantly soiled carpet throughout the space. Not only was the carpet covered with dust and debris from the wall damage, but it was also covered with cigarette butts, garbage, and heavy staining.	0 800			

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0 800	Continued From page 19 It was observed that bedroom #1 had the closet doors removed, and damage done to the wood trim and walls of the closet. Half of the wood trim for the closet was missing leaving broken drywall and nails exposed to the room. Large gouges had been taken out of the corners of the walls forming the closet leaving the unfinished construction materials exposed to the room. CNS-A and PM-C stated that the resident who previously lived in the room had done all the damage after being discharged from the facility. It was observed that the carpet throughout the facility was heavily soiled. Wear patterns could be seen through the hallways, stairs, and other common areas. The carpet in all the bedrooms was similarly soiled. It was observed that the carpet had been removed from the stairs leading into the lower level leaving the unfinished treads exposed. The stair treads and risers had large gaps at the joints. There were no stair nosings on the treads to prevent someone's toe from catching on the open joint and causing a fall. Carpet tacks could still be seen and felt at the top stair landing and on the sides of some of the stair treads. It was observed that furniture provided by the licensee for use by the residents in the common area was broken. A recliner in the upstairs living room was completely broken down and the seat was falling out of the chair structure. It was observed that the lower level common area had been filled with miscellaneous furniture, bikes, decorations, and equipment to the point where it was not usable as a common space and some of the items obstructed the path of egress from the adjacent office space.	0 800			

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0 800	Continued From page 20 CNS-A and PM-C visually verified these deficient findings at the time of discovery. 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 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	0 810		

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0 810	Continued From page 21 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on October 31, 2023, with the licensed assisted living director (LALD)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to evacuate the building but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency.	0 810			

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0 810	Continued From page 22 During interview, LALD-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-E stated the licensee was completing employee training upon hire and then annually. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD-E verified that the licensee was	0 810			

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0 810	Continued From page 23 not completing the correct number of drills per year, and had not been documenting on which shift the evacuation drills were done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three current residents. This had the potential to affect all residents living in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 910		

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0 910	Continued From page 24 The findings include: On October 30, 2023, at 11:55 a.m., the surveyor requested for licensee's contract. Clinical nurse supervisor (CNS)-A gave the surveyor a blank contract and stated the same contract was used for all licensee's residents. The licensee's Resident Agreement Assisted Living Summary of Important Terms lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On October 31, 2023, at 3:30 p.m., CNS-A stated licensee was not aware of the requirement and all resident contracts will be missing the HFID number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970			

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0 970	Continued From page 25 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for all three (3) current residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On October 30, 2023, at 11:55 a.m., the surveyor requested for licensee's contract. Clinical nurse supervisor (CNS)-A provided the surveyor a blank contract and stated the contract was used for all licensee's resident. The licensee's contract had two sections with a liability language: - Section indemnification read - resident will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. - Section liability read - Provider is not liable to resident or resident's guests for any injury, death	0 970			

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0 970	Continued From page 26 or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third party providers. the provider may be liable to resident for its own negligent acts or those of its employees or agents. On October 31, 2023, at 3:45 p.m., licensed assisted living director (LALD)-E stated he thought the licensee had amended the liability language in the contract and was surprised the same liability language was still in resident contracts. LALD-E also stated will contact their attorneys for the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01290 SS=F	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.	01290			

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01290	Continued From page 27 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to staff providing services for one of two employees (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: ULP-B started employment with licensee on November 8, 2023. ULP B's employee record included a Background Study Clearance letter dated November 13, 2022, affiliated to HFID 34600. ULP-B's record lacked evidence of a completed background study clearance affiliated with the licensee's HFID 35842. On October 31, 2023, at 3:45 p.m., licensed assisted living director (LALD)-E stated ULP-B had not been affiliated to licensee's HFID 35842. LALD-E stated he thought he had done it	01290		

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01290	Continued From page 28 previously for all employees but discovered in addition to ULP-B, he had more employees that he had to affiliate immediately. The licensee's Background Studies policy dated August 1, 2021, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for [licensee] will be maintained including results of background studies. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed person (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370			

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01370	Continued From page 29 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required training areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B	01370			

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01370	Continued From page 30 ULP-B started employment with licensee November 8, 2022. ULP-B's record lacked the following required trainings and competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting ; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D started employment with licensee December 9, 2022. ULP-B's record lacked the following required trainings and competency evaluations: - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - awareness of commonly used health technology equipment and assistive devices. On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated ULP-B and ULP-D lacked required training. In addition, CNS-A stated licensee had assigned all training topics to all employees. Also, CNS-A stated she had not checked each employee's file to confirm if work assigned was completed.	01370			

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NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
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01370	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required training areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01380			

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01380	Continued From page 32 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: ULP-B ULP-B started employment with licensee November 8, 2022. ULP-B's record lacked the following required trainings and competency evaluations: - recognizing physical, emotional, cognitive, and developmental needs of the resident; - range of motioning and positioning; and - Other RN/professionally delegated tasks. ULP-D ULP-D started employment with licensee December 9, 2022. ULP-D's record lacked the following required trainings and competency evaluations: - reading and recording temperature, pulse, and respirations of the resident; - range of motioning and positioning; and - Other RN/professionally delegated tasks. On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated ULP-B and ULP-D lacked required training. In addition, CNS-A stated licensee had assigned all training topics to all employees. Also, CNS-A stated she had not checked each employee's file to confirm if work assigned was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500			

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01500	Continued From page 34 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B started employment with licensee November 8, 2022.	01500			

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01500	Continued From page 35 ULP-B's record indicated ULP-B had completed annual training on the following topics for a total of two (2) hours: - infection control techniques - 1 hour - dementia training - 1 hour ULP-B's employee record lacked documentation of six additional hours to meet the eight hours of annual training required to be completed within the last year, in the following required topics: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - review of provider's policies and procedures; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - dementia training. ULP-D started employment with licensee December 9, 2022. ULP-D's record indicated ULP-D had completed annual training on the following topics for a total of four (4) hours: - reporting maltreatment of vulnerable adults or minors- 1 hour; - infection control techniques- 1 hour; and - principles of person-centered planning/service delivery- 1 hour; and - dementia training - 1 hour ULP-D's employee record lacked documentation of four additional hours to meet the eight hours of annual training required to be completed within the last year, in the following required topics: - assisted living bill of rights; - review of provider's policies and procedures; and - hearing loss training (optional); and	01500			

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01500	Continued From page 36 - dementia training. On October 31, 2023, at 3:40 p.m., clinical nurse supervisor (CNS)-A stated all employees should receive at least eight hours of annual training. CNS-A also stated licensee assigns annual training topics but had not gone back to ensure all employees completed their assigned work. The licensee's Annual Training Requirements policy dated August 1, 2021, indicated all staff providing direct care will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01530			

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01530	Continued From page 37 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 working hours of the employment start date for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-D started employment with the licensee on December 9, 2022. ULP-D's My Transcript indicated ULP-D had completed dementia training in the following topics for a total of 6.25 credits: 1. introduction and overview (1.00 credit); 2. communication (1.25 credits); 3. activities of daily living (1.00 credit);	01530			

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01530	Continued From page 38 4. behaviors verses symptoms (1.00 credit); 5. the journey (0.75 credits); and 6. dementia management and abuse prevention (1.25 credits). On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the required number of hours for dementia care training required. CNS-A also stated during orientation employees were assigned dementia topics to complete however, the number of hours assigned may not be sufficient to cover the required hours. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff will receive required dementia training at the time of hire and annually thereafter. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620			

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01620	Continued From page 39 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment not to exceed 14-days and 90 calendar days from the date of the last review for two of two residents (R1 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1's Home Care Service Plan dated February 28, 2023, indicated R1 received the following services: monitoring and reassessment, medication management, and unlicensed	01620			

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01620	Continued From page 40 personnel (ULP) supervision. R1's record had three Clinical Update Assessments dated February 28, 2023, March 31, 2023, and June 2, 2023. R1's 14-day assessment dated March 31, 2023, was 31 days after the initial assessment was completed on February 28, 2023. R1's record lacked any other assessments after the last 90-day assessment dated June 2, 2023. R4 R4's Home Care Service Plan dated April 25, 2023, indicated R4 received the following services: monitoring and reassessment, medication management, personal care service, and ULP supervision. R4's record had three Clinical Update Assessments dated April 26, 2023, May 16, 2023, and August 21, 2023. R4's 14-day assessment dated May 16, 2023, was 20 days after the initial assessment which was completed on April 26, 2023. R4's 90-day assessment dated August 21, 2023, was 97 days after the 14-day assessment dated May 16, 2023, was completed. On October 31, 2023, clinical nurse supervisor (CNS)-A stated R1 and R4's assessments were late and blamed the licensee system of manual tracking for the late assessments. CNS-A also stated licensee had a hard time to complete R1's assessments as R1 refused almost everything from the staff. The licensee's Nursing Assessment Schedules policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring will be completed in person as needed based on changes in the needs of the resident but cannot	01620			

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01620	Continued From page 41 exceed 90 calendar days from the last date of the assessment. The policy lacked verbiage to include 14-day assessments. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content for	01910			

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01910	Continued From page 42 one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was discharged from the licensee on January 1, 2023. On October 30, 2023, at 1:44 p.m., project manager (PM)-C stated R3 received medication management services when R3 resided at licensee's facility. R3 lacked a medication disposition record with required content to include: - medication name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. On October 31, 2023, at 3:40 p.m., clinical nurse supervisor (CNS)-A stated R3's record lacked a medication disposition record. Project manager (PM)-C stated the licensee had transferred R3's records to another location owned by the licensee but that facility burned down and destroyed the records.	01910		

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01910	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	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 44 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 the required content for one of one resident with a treatment (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 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: R1's Home Care Service Plan dated February 28, 2023, indicated R1 received the following services: monitoring and reassessment, medication management, and unlicensed personnel (ULP) supervision. R1's diagnoses were major depression, anxiety, alcohol dependency, and chronic obstructive pulmonary disease (COPD). On October 30, 2023, at 12:56 p.m., the surveyor observed R1 in bed in her room wearing an oxygen nasal cannula tube. R1 stated she needed oxygen because of her COPD. On October 30, 2023, at 1:20 p.m., project manager (PM)-C stated R1 received 2-3 liters of oxygen per hour, and that unlicensed personnel were responsible to monitor R1 while in her room. R1's treatment or therapy management plan	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
(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
01940	Continued From page 45 lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received. On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated licensee had not written statement of the treatment or therapy services that will be provided to the resident and also had not developed a current individualized treatment and therapy management record for R1. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated licensee's 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: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
(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
01940	Continued From page 46 health professional when a problem arises related to the treatment or therapy service No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) with treatments (oxygen). 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:	01970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
(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
01970	Continued From page 47 R1's diagnoses were major depression, anxiety, alcohol dependency, and chronic obstructive pulmonary disease (COPD). R1's Home Care Service Plan dated February 28, 2023, indicated R1 received the following services: monitoring and reassessment, medication management, and unlicensed personnel (ULP) supervision. On October 30, 2023, at 12:56 p.m., the surveyor observed R1 in bed in her room wearing an oxygen nasal cannula tube. R1 stated she needed oxygen because of her COPD. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for oxygen to include a description of the treatment or therapy to be provided, frequency, duration, and resident oxygen parameters. On October 31, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated licensee did not have written or electronically recorded order from an authorized prescriber for R1's oxygen. CNS-A also stated licensee had requested for the orders several times from the provider but had not received them to date. The licensee did not have copies of the said requests sent to provider. The licensee's undated Treatment and Therapy Management Plan policy indicated licensee will request orders based on the individual resident needs, provide treatments or therapy, education to residents, and document services provided and communication with prescribers. No further information was provided.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
(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
01970	Continued From page 48 TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

Type: Full
Date: 10/30/23
Time: 14:18:15
Report: 1018231196

Food and Beverage Establishment Inspection Report

Page 1

Location:

Golden Touch Health Care Llc
8216 Hampshire Court North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:

ID #: 0038997
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633541112
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR.
COMPLY WITH RULE.

Comply By: 10/31/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

EDGE OF COUNTER TOP BEHIND THE SINK IS DAMAGED AND COMING OFF THE WALL.
CABINET DOOR MISSING AND OTHER CABINET DOORS DAMAGED. DISCUSSED WITH
MANAGER TO REPAIR THESE ITEMS.

Comply By: 10/31/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED FOOD SPLATTER ON WALLS AND CEILINGS. DISCUSSED WITH MANAGER TO HAVE
THESE SPACES CLEANED.

Comply By: 10/31/23

Food and Equipment Temperatures

Type: Full
Date: 10/30/23
Time: 14:18:15
Report: 1018231196
Golden Touch Health Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding/ CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH 3 RESIDENTS.

ALL FOOD IS PREPARED FOR SAME DAY AND NO COOLING HAPPENS IN THE FACILITY.

DISHWASHER HAS SANITIZE FUNCTION AND TEMPERATURE STICKER CONFIRMED
APPROPRIATE TEMPERATURE WAS REACHED INSIDE THE MACHINE.

FLOORS, WALLS, CEILINGS AND EQUIPMENT ARE ALL RESIDENTIAL AND WILL BE
MONITORED THROUGH THE YEARS.

DISCUSSED EMPLOYEE ILLNESS, ILLNESS REPORTING AND PEST CONTROL.

ESTABLISHMENT HAS 2 BASIN HAND SINK WITH ONE SIDE DESIGNATED FOR HAND WASHING
ONLY.

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

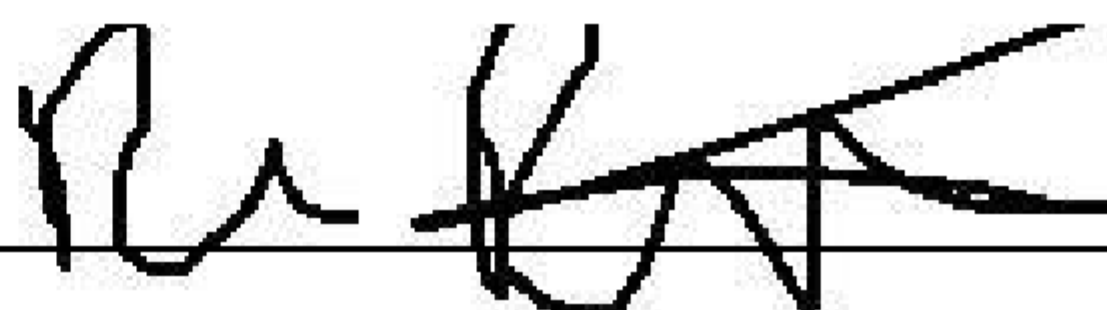
I acknowledge receipt of the Minnesota Department of Health inspection report
number 1018231196 of 10/30/23.

Certified Food Protection Manager ESTHER DISUE AGBOR

Certification Number: FM110537 Expires: 03/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
SWEETEE MILLER
MANAGER

Signed:  _____
2204 Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us