STATE LICENSING COMPLIANCE REPORT

Report #: HL242646259C

Date Concluded: April 10, 2025

Name, Address, and County of Facility Investigated:
Golden Valley Residence
1940 Major Drive
Golden Valley MN 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24264	A. BUILDING: _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY RESIDENCE	1940 MAJOR DRIVE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL242646259C HL242647362M/HL242642403C On March 26, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were five residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL242646259C, tag identification 590. The follow correction order is issued for HL242647362M/HL242642403C, tag identification 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees	0 590		

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0 590	Continued From page 1 that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to refrain from acting as representative payee of the resident, as required for 1 of 1 residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes chronic kidney disease and heart failure. R1's plan of care dated April 1, 2025, indicated R1 received assistance with	0 590	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.	

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0 590	Continued From page 2 transfers, toileting, medication administration, behavior management, dressing, and safety checks every two hours. A document, untitled, provided by the licensee, dated August 23, 2023, indicated the licensee requested to be the payee of R1's social security benefit checks. R1's individual abuse prevention plan (IAPP) dated November 1, 2024, indicated R1 required shopping assist from staff. R1's service delivery records dated December 2024, January 2025, February 2025 and March 2025, did not indicate R1 received assistance with financial needs. R1's social security checks dated February 12, 2025, for $1,673.00 and March 12, 2025, for $1,673.00 were written to pay to the order of the licensee. A licensee bank statement dated February 28. 2025, indicated a deposit of $1,673.00, same amount of R1's social security checks. R1's plan of care dated April 1, 2025, did not indicated R1 required assistance with finances. During an interview on March 26, 2025, at 9:15 a.m., R1 stated her bills go directly to the office and if she needs money, she goes to the office to ask for it. R1 stated she does not see her money and does not receive any statements. During an interview on April 3, 2025, at 1:05 p.m., owner (OW)-A stated R1 admitted to them from another facility who was acting as R1's representative payee, and told OW-A R1 did not	0 590	PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 590	Continued From page 3 have her own bank account. OW-a stated he was not happy to have to manage R1's finances. OW-A stated the facility was the representative payee for R1. OW-A stated R1's social security checks came directly to the facility and were deposited into the facility business account. OW-A stated the facility paid R1's bills for her. OW-A stated the facility did not make any attempts to obtain a guardian or power of attorney for R1. OW-A stated he was not aware a facility could not act as a representative payee for a resident, and since R1's previous facility was acting as R1's representative payee, he did not think twice about it. The licensee policy titled "Handling of Resident's Finances" dated July 29, 2021, indicated no staff can assist with household budgeting, including paying bills, or otherwise manage a resident's property. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 590		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 4 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document medication administration and follow up procedures when a medication was not administered as ordered, as required for 1 of 1 residents (R1) reviewed. This deficient practice affected all staff and had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the facility August 15, 2024. R1's diagnosis includes Parkinson's disease and failure to thrive. R1's plan of care printed December 9, 2024, indicated R1 received medication administration service, effective August 14, 2024, during the morning and evening shift. Effective August 23, 2024, medication reminder service was added for a verbal reminder on the overnight shift to R1 to take his overnight medication as scheduled. Effective August 30, 2024, medication administration service was added for the overnight shift. R1's admission physician orders, signed August 13, 2024, included orders for carbidopa-levodopa	01760	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31	

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01760	Continued From page 5 25-250 milligrams (mg) every four hours for Parkinson's disease, midorine 10 mg three times per day for low blood pressure and Synthroid 75 micrograms daily for hypothyroidism. R1's medication administration record (MAR) dated August 2024, indicated R1 had carbidopa-levodopa scheduled at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. starting on August 16, 2024. The incorrect dose of midorine was transcribed to the MAR of 5 mg and not 10 mg as ordered. Midorine was scheduled at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Synthroid was scheduled at 8:00 a.m., but with directive as self administration. The following omission medication errors: carbidopa-levodopa: August 16, 2024, through August 30, 2024, R1's MAR lacked documentation for administration of 72 doses of R1's carbidopa-levodopa medication, no documentation of administration occurred until the 8:00 a.m. dose on August 30, 2024. midodrine: August 17, 2024, 12:00 p.m. dose, reason documented "took out." August 23, 2024, 8:00 a.m. dose, reason documented did not have medication set up. Additionally, no medications were documented as administered on August 25, 2024, and R1's record lacked indication he was not in the facility. R1's nurse notes dated August 30, 2024, at 1:24 p.m. indicated staff noted R1 to be incorrectly taking his Synthroid medication. The note indicated facility staff will complete R1's medication administration going forward.	01760	SUBDIVISION 1-3.	

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01760	Continued From page 6 R1's MAR notes dated September 2024, indicated following omission medication errors: carbidopa-levodopa: September 18, 2024, 12:00 p.m. dose, reason "out." September 23, 2024, 8:00 a.m. dose, no documentation. Synthroid: R1 did not receive any Synthroid September 1, 2024 through September 11, 2024 and the first dose administered on September 12, 2024. September 23, 2024, 8:00 a.m. dose, no documentation. midodrine: September 18, 2024, 12:00 p.m. dose, reason "out." R1's MAR notes dated October 2024, indicated following omission medication errors: carbidopa-levodopa: October 2, 2024, 12:00 a.m. and 4:00 a.m. dose, reason not available, although it was administered the day prior and all doses afterwards. R1's MAR notes dated November 2024, indicated following omission medication errors: midodrine: November 7, 2024, 8:00 a.m., 12:00 p.m. and 4:00 p.m. dose, reason "none" and not available. November 9, 2024, 8:00 a.m. dose, reason "none." November 10, 2024, 4:00 p.m. dose, reason not available. November 11, 2024, 12:00 p.m. dose, reason "none." November 12, 2024, 12:00 p.m. and 4:00 p.m. dose, reason "none" and not available	01760		

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01760	Continued From page 7 November 13, 2024, 8:00 a.m. dose, reason "none." R1's record lacked follow up or monitoring of R1 missing his Parkinson's medication, blood pressure medication, and Synthroid. R1's plan of care indicated effective November 10, 2024, blood pressure monitoring service daily was added with directive to notify the nurse if the upper number is less than 100 or higher than 160 or lower number is less than 90 or higher than 95. Pulse monitoring service daily was also added with directive to notify the nurse if the pulse is less than 60 or higher than 100. Effective November 13, 2024, directive for staff to give midodrine at 8:00 a.m., 12:00 p.m. and 4:00 p.m. The medication is in a bottle and needed to be given daily as prescribed. R1's medication management plan dated December 9, 2024, indicated R1 had provider orders to self-administer his nasal spray, Synthroid medication, and carbidopa-levodopa medication doses at 2:00 a.m. and 4:00 a.m. The plan indicated staff noted R1 to be incorrectly dosing his Synthroid medication. The plan lacked documentation of the assessment from a nurse that indicated R1 was appropriate to self-administer medications. During an interview on March 26, 2025, at 10:15 a.m., unlicensed personnel (ULP)-A stated the nurse comes to the facility three to four times a week to do resident medications. ULP-A stated she calls or texts the nurse if she has any issues. During an interview on April 7, 2025, at 2:00 p.m., registered nurse (RN)-B stated the staff did not sign R1's MAR for the administration of	01760		

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01760	Continued From page 8 carbidopa-levodopa because R1 took it himself. RN-B stated she checks on what the ULP are charting and noted they charted they did not have midodrine medication for R1, and upon further inspection, noted it had not been delivered from the pharmacy. RN-B stated R1 missed three doses of midodrine in November, and did not miss any in October. RN-B stated she never received any complaints or concerns about how R1 took his carbidopa-levodopa medication, only concerns with the Synthroid medication. During an interview on April 8, 2025, at 10:38 a.m., ULP-C stated the nurse has medications for every resident set up. ULP-C stated there was one time she could not find the resident's blood pressure medication, so she called a coworker who told her it was next to the cassette, and that's where she found it. The licensee policy titled "Administration of Medication, Treatment and Therapy by Unlicensed Personnel" dated August 1, 2021, indicated resident medications must be administered according to the six rights of medication administration. The sixth right indicated the resident has the right to the right charting record to document that the medication was taken. The licensee policy titled "Documentation of Medication, Treatment and Therapy Management Services" dated August 1, 20221 indicated staff will document each task immediately after that task has been performed. The policy indicated the RN will document actions to request and obtain needed refills for resident's, including communications with the prescriber, pharmacy, resident and or the resident's representative or family.	01760		

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01760	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		