Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 20, 2025

Licensee
Golden Pond Maple Grove
12270 87th Avenue North
Maple Grove, MN 55369

RE: License Number 417050
Health Facility Identification Number (HFID) 27329
Project Number(s) SL27329015

Dear Licensee:

On January 13, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed June 13, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 20, 2025.

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.

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,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 15, 2024

Licensee
Golden Pond Maple Grove
12270 87th Avenue North
Maple Grove, MN 55369

RE: Conditional License Number 417050
Health Facility Identification Number (HFID) 27329
Project Number(s) SL27329015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on September 3, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 13, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 (a), state correction orders issued pursuant to the last survey, completed on June 13, 2024, found not corrected at the time of the September 3, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on September 3, 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.

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Golden Pond Maple Grove a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Golden Pond Maple Grove is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **Health Facility Construction Permit:** Golden Pond Maple Grove, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Golden Pond Maple Grove, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Golden Pond Maple Grove must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:

   i. Name
   ii. License Number
   iii. Contact Information

c. **Egress Window Requirements:** Golden Pond Maple Grove will replace at least one window in unoccupied resident sleeping room #5 and #6 meeting the minimum size requirements.

   i. Must have a minimum openable width of no less than 20 inches
   ii. Must have a minimum openable height of no less than 20 inches
   iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
   v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Golden Pond Maple Grove is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Golden Pond Maple Grove is in substantial compliance on the follow up survey, MDH will remove the conditions from Golden Pond Maple Grove's assisted living facility license, and Golden Pond Maple Grove will correct any outstanding violations identified during the survey. If Golden Pond Maple Grove is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit
https://forms.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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27329	A. BUILDING: _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND MAPLE GROVE	12270 87TH AVENUE NORTH MAPLE GROVE, MN 55369

(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, 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: SL#27329015-1 On September 3, 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 June 13, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 SUBDIVISION 1-3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{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,	{0 480}		

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 3 (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}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to	{0 700}		

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{0 700}	Continued From page 4 control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: No further action required.	{0 700}		
{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 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:	{0 780}		

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{0 780}	Continued From page 5 No further action required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{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: No further action required.	{0 800}		

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{0 820}	Continued From page 6	{0 820}		
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{0 820}		

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{0 820}	Continued From page 7 The findings include: On September 3, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on June 13, 2024. On September 3, 2024, at 12:40 p.m., survey staff toured the facility with unlicensed assisted personnel (ULP)-B. During the tour, survey staff asked ULP-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Unoccupied Sleeping Rooms: Basement Bedroom #5: Two windows measuring 16 inches clear width, 56 inches clear height, and 896 square inches total open area for each window. Basement Bedroom #6: Two windows measuring 16 inches clear width, 56 inches clear height, and 896 square inches total open area for each window. The windows in basement bedrooms #5, and #6 did not meet the minimum requirements for opening width. The hardware on the casement windows moved the windowpane into the window opening and reduced the clear width that did not meeting the required minimum clear width for egress. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 8 standard for an egress window to be a complying bedroom for resident occupancy. ULP-B verbally confirmed the findings. No Further information was provided.	{0 820}		
{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}		
{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.	{01620}		

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{01620}	Continued From page 9 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		

Electronically Delivered

July 24, 2024

Licensee
Golden Pond Maple Grove
12270 87th Avenue North
Maple Grove, MN 55369

RE: Project Number(s) SL27329015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 MDH within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27329	A. BUILDING: _____ B. WING _____	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND MAPLE GROVE	12270 87TH AVENUE NORTH MAPLE GROVE, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27329015-0 On June 10, 2024, through, June 13, 2024, 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 four residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year. 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	0 470		

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0 470	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written staffing plan including all required content and evaluated twice per year. On June 10, 2024, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated, "I usually just do the monthly schedule based on the patient's needs". LALD/CNS-C indicated they were not aware they needed to develop and implement a written staffing plan with an evaluation completed at least twice a year. The licensee's 4.06 Staffing & Scheduling policy dated June 10, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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:	0 480		

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0 480	Continued From page 3 (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 June 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	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:	0 650		

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0 650	Continued From page 4 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for two or two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 650		

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0 650	Continued From page 5 The findings include: ULP-A ULP-A was hired on May 20, 2010. On June 11, 2024, at 8:22 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-B ULP-B was hired on March 26, 2020. ULP-A and ULP-B's records lacked documentation of competency evaluations related to medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home. On June 12, 2024, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they provided the training when they reviewed the policies with staff at the time of hire. Staff are trained on where to put the medications and there is a sheet staff print out to send with residents to be completed by a responsible party when medications are administered outside of the home. Also, LALD/RN-D stated staff completed an in-service online called, "Assisting residents with appointments" under the medication training which included unplanned times away. LALD/RN-D acknowledged competency was not documented in the employee record by a registered nurse to indicate the ULP's were competent to provide medications for residents with unplanned time away from home. The licensee's 7.10 Medication Management -	0 650		

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0 650	Continued From page 6 Planned & Unplanned Time Away policy dated August 1, 2021, indicated staff would be trained and found competent by an RN with planned and unplanned times away. Additionally, the licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would include competency testing as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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.	0 680		

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0 680	Continued From page 7 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency disaster preparedness (EP) plan including all required content. This affected all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked evidence of the following required content: - process for EP collaboration; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - development of Communication Plan; - emergency officials contact information including Federal, State, tribal, regional and local EP staff, State licensing and Certification Agency and Minnesota Office of Ombudsman for Long Term Care (OOLTC); - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training program; and	0 680		

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0 680	Continued From page 8 - emergency prep testing requirements. On June 13, 2024, at 1:29 p.m., licensed assisted living director/registered nurse (LALD/RN)-D acknowledged the EP plan was not complete and missed required information and licensee would update the EP plan to reflect the requirements. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated June 1, 2021, indicated [licensee] would have in place an emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident's personal health and medical information were kept private for four of four residents (R1, R2, R3,	0 700		

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0 700	Continued From page 9 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: On June 10, 2024, at 11:06 a.m., the surveyor observed four binders containing resident medical records for R1, R2, R3, and R4 that were unsecured in a common area on the lower level of the facility. R1 had discharged from the facility on October 28, 2023, and the other medical records were for current residents receiving assisted living services. On June 13, 2024, at 1:49 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they don't allow any visitors or residents downstairs. LALD/RN-D indicated licensee had been in the process of getting a locked metal cabinet for storage of past medical records to be more organized. The licensee's 2.36 Resident Record - Confidentiality policy dated August 1, 2021, indicated resident records would be kept confidential and locked in a secured area where only authorized staff of [licensee] would have access. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 700		

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0 700	Continued From page 10 (21) days	0 700		
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 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 that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 11 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 June 10, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C. It was observed that the bedrooms in the lower level (not numbered) were equipped with smoke alarms but were not interconnected with the other smoke alarms in the dwelling unit so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by LALD/CNS-C accompanying on the tour. During interview on June 10, 2024, at 1:30 p.m., LALD/CNS-C stated that they understood the requirement for the smoke alarm and would get them interconnected. LALD/CNS-C stated that the bedrooms on the lower level were no longer being used as bedrooms for residents. The rooms were identified on the egress diagrams as bedrooms and were set up as bedrooms with furniture such as beds, nightstands, and dressers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790	Continued From page 12	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 10, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C. It was observed that the portable fire	0 790		

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0 790	Continued From page 13 extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During an interview on June 10, 2024, at 1:30 p.m., survey staff explained to LALD/CNS-C that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/CNS-C verified the findings and stated that they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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.	0 800		

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0 800	Continued From page 14 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 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 June 10, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C. The following was observed. Egress Windows: It was observed in bedroom #5 that the egress window was difficult to open. Egress windows must be provided, have a clear path of access, and be properly maintained to allow for the proper function in buildings not equipped with an automatic sprinkler system. General Maintenance: It was observed that there was a large hole in the closet ceiling in basement bedroom #5.	0 800		

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0 800	Continued From page 15 It was observed that there were two outlet in the staff room that did not have outlet covers. It was observed that the living room area in the basement had an access panel missing its cover. During an interview on June 10, 2024, at 1:30 p.m., LALD/CNS-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum	0 820		

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0 820	Continued From page 16 state standard for egress. This had the potential to affect some 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 10, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C. During the tour, survey staff asked LALD/CNS-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Unoccupied Sleeping Rooms: Basement Bedroom #5: Two windows measuring 16 inches clear width, 56 inches clear height, and 896 square inches total open area for each window. Basement Bedroom #6: Two windows measuring 16 inches clear width, 56 inches clear height, and 896 square inches total open area for each window. The windows in basement bedrooms #5, and #6 did not meet the minimum requirements for opening width. The hardware on the casement windows moved the windowpane into the window opening and reduced the clear width that did not meeting the required minimum clear width for egress	0 820		

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0 820	Continued From page 17 Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/CNS-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-C verbally confirmed the findings. No Further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
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	01290		

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01290	Continued From page 18 by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was associated with the licensee's current assisted living facility's health facility identification number (HFID) for two of two unlicensed personnel ((ULP)-A, 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-A ULP-A was hired on May 20, 2010. ULP-A's Department of Human Services BGS clearance dated February 9, 2024, indicated ULP-A was cleared and associated with another licensee's HFID 36447. The BGS was not associated with the licensee's HFID 27329 where ULP-A provided care to residents. ULP-B ULP-B was hired on March 26, 2020. ULP-B's Department of Human Services BGS clearance dated April 20, 2023, indicated ULP-B was cleared and associate with another licensee's HFID 27328. The BGS was not associated with the licensee's HFID 27329 where ULP-B provided care to residents. On June 12, 2024, at 10:54 a.m., licensed	01290		

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01290	Continued From page 19 assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware background studies had to be affiliated to each licensee's HFID and indicated licensee would affiliate all employees providing care in the facility to the licensee's HFID. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated licensee would complete a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors at the facility. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01290		
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	01620		

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01620	Continued From page 20 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 a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of two residents (R3). Also, the licensee failed to ensure the RN conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 R2 was admitted on June 7, 2019. R2's service plan effective March 21, 2024, indicated R2 received the following services: assistance with morning and bedtime cares, bathing, continence care, mobility assistance,	01620		

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01620	Continued From page 21 medication administration, housekeeping, shopping assistance, and food preparations. R2's record included 90-day nursing assessments dated September 12, 2023, December 18, 2023, and March 17, 2024. The assessment completed on December 18, 2023, indicated 97 days had passed since the previous assessment completed on September 12, 2023. R3 R3 was admitted on April 8, 2021. R3's service plan effective March 21, 2024, indicated R3 received the following services: assistance with morning and bedtime cares, bathing assistance, continence care, transferring, medication administration, housekeeping, assist with transportation, and food preparations. R3's record included 90-day nursing assessments dated July 26, 2023, October 29, 2023, January 23, 2024, and April 23, 2024. The assessment completed on October 29, 2023, indicated 95 days had passed since the previous assessment completed on July 26, 2023; and the assessment completed on April 23, 2024, indicated 91 days had passed since the previous assessment completed on January 23, 2024. R3's 90-day nursing assessments dated July 26, 2023, October 29, 2023, January 23, 2024, and April 23, 2024, were documented using a form titled Comprehensive Nursing Assessments. The Comprehensive Nursing Assessment form failed to address the required content per the Uniform Assessment Tool to include the following information for each assessment: -the resident's personal lifestyle preferences; -activities of daily living;	01620		

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01620	Continued From page 22 -instrumental activities of daily living; -physical health status that includes vital signs, weight, and medications (reason, side effects, dose, frequency, route, difficulties with taking meds, how resident takes meds, interventions needed to prevent diversion including instruction to resident/family on interventions to prevent diversion); -communication capabilities; -skin conditions; -hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -who has decision-making authority for the resident; and -the need for follow-up referrals for additional medical or cognitive care by health professionals. On June 12, 2024, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated the Comprehensive Nursing Assessment form was an old form the facility used and was not aware it did not have all the required content identified per the Uniform Assessment Tool. LALD/CNS-C stated the licensee would use the assessment provided through their documentation system, which had all the required content, going forward for all residents. Also, LALD/CNS-C indicated they were not aware of the late assessments and would create an alarm to make sure they do not exceed 90 calendar days from the last date of assessment. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, included assessment schedule with appropriate timing,	01620		

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01620	Continued From page 23 and indicated the individualized review or subsequent reviews would include all the required elements as specified in Rule, conducted in person, be in writing, dated and signed by the registered nurse who conducted the individualized review but failed to identify all areas to be assessed as required per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 24 review, the licensee failed to ensure medications were stored securely for two of two residents (R2, R4) with medication management services; and failed to monitor a medication refrigerator to ensure temperatures were maintained according to the manufacturer's instructions for two of two residents (R2, R4) with medications stored in medication refrigerator. 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: STORAGE R2 R2 was admitted on June 7, 2019, with diagnoses including Congested Heart Failure and Diabetes. R2's Service Plan dated March 21, 2024, indicated R2 received assistance with medication administration, medication refills and medication setup. R2's Assessment As Of Date dated March 17, 2024, under Med Management, indicated staff were to make sure all medication are secured and locked in the medication storage cabinet. On June 10, 2024, at 11:03 a.m., during a facility tour, the surveyor observed R2's room and noted unsecured medications sitting in a small basin (container without a cover). The following	01880		

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01880	Continued From page 25 medications were identified: - Diclofenac 1% gel; and - Ammonium lactate 12% cream. On June 10, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated, "this is the cream, we want this always available". LALD/CNS-C also stated the resident is unable to manage medications and they were unsure why the medications were found in the room. The surveyor observed LALD/CNS-C immediately remove the unsecured medications and stored the medications in the locked medication closet. R4 R4 was admitted on May 18, 2017, with diagnoses including insulin dependent diabetes mellitus. On June 10, 2024, at 10:50 a.m., during a facility tour, the surveyor observed R4's room and noted several unsecured medications stored in an uncovered container on a stand next to the resident's bed and one medication sitting on the resident's dresser. The following medications were identified as being unsecured: - Ammonium lactate 12% Cream; - Fluticasone propionate/salmeterol diskus 500/50 microgram (mcg); - Albuterol Aerosol inhaler; - Albuterol sulfate nebulizer vials; and - Artificial Tears. On June 10, 2024, at 10:54 a.m., LALD/CNS-C stated licensee managed R4's medication and was not sure why R4 had medication in their room. The surveyor observed LALD/CNS-C immediately remove the unsecured medications and stored the medications in the locked	01880		

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01880	Continued From page 26 medication closet. REFRIGERATOR On June 11, 2024, at 10:42 a.m., the surveyor observed a locked medication refrigerator located in a common dining room area. The refrigerator temperature was 44 degrees Fahrenheit (F) upon opening refrigerator. The surveyor observed unopened resident insulin pens (an insulin delivery system resembling a large pen) stored in the medication refrigerator as followed: - R2's Lantus solostar 100 unit/milliliter (ml) - R4's Humalog kwikpen 100 unit/ml - R4's Lantus solostar 100 unit/ml - R4's basaglar 100 unit/ml The licensee lacked a medication refrigerator temperature log to record temperatures to ensure medication is stored per manufacturer's instructions. The manufacturer's instructions for Lantus Solostar pen revised November 2023, indicated to store unused pens in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F and not to use if the pen had been frozen. The manufacturer's instructions for Humalog Kwikpen revised August 2023, indicated to store unused pens in the refrigerator at 36 degrees F to 46 degrees F and not to use if the pen had been frozen. The manufacturer's instructions for Basaglar Kwikpen revised November 2023, indicated to store unused Pens in the refrigerator at 36 degrees F to 46 degrees F and not to use if the pen had been frozen. On June 11, 2024, at 10:42 a.m., the unlicensed	01880		

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GOLDEN POND MAPLE GROVE	12270 87TH AVENUE NORTH MAPLE GROVE, MN 55369

(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
01880	Continued From page 27 personnel (ULP)-E indicated the licensee did not have a daily temperature log for the medication refrigerator. On June 11, 2024, at 11:03 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee used to have one however they no longer had one due to an oversight. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated the licensee would keep medications securely locked and store medications per manufacturer's instruction when licensee managed medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health

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

Type: Full
Date: *06/10/24*
Time: 11:10:00
Report: 1051241029

Food and Beverage Establishment Inspection Report

Location:
Golden Pond Maple Grove
12270 87th Avenue North
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0038965
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634477717
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.

AT TIME OF INSPECTION, RAW SHELL EGGS WERE STORED ABOVE MILK IN THE TWO-DOOR UPRIGHT COOLER.

Comply By: 06/10/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

AT TIME OF INSPECTION, AMBIENT TEMPERATURE FOR TWO-DOOR UPRIGHT COOLER WAS AT 45 F. MILK WAS AT 42 F. ADJUST UNIT COOLER.

Comply By: 06/10/24

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION, THERE WAS NO CFPM. HAVE STAFF TAKE AN APPROVED COURSE AND SUBMIT PASSING RESULTS WITH INITIAL CFPM APPLICATION TO THE STATE. APPLICATION EMAILED WITH REPORT.

Comply By: 08/10/24

Food and Equipment Temperatures

Type: Full
Date: *06/10/24*
Time: 11:10:00
Report: 1051241029
Golden Pond Maple Grove

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Air
Temperature: 45 Degrees Fahrenheit - Location: TWO-DOOR UPRIGHT COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 42 Degrees Fahrenheit - Location: MILK-TWO DOOR UPRIGHT COOLER
Violation Issued: Yes

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

THE FACILITY WAS INSPECTED BY KAI YANG (MDH).

MET WITH NURSE EVALUATOR, RHAWNIE QUINEHAN AND ENGINEERING INSPECTOR, STEPHANIE JONES DE PALMA.

DISCUSSED THE FOLLOWING WITH CNA STAFF, SHANIA:

EMPLOYEE ILLNESS LOG (EMAILED WITH REPORT)
VOMIT CLEAN-UP PROCEDURE
HIGHLY SUSCEPTIBLE POPULATION

THE KITCHEN HAS AN NSF 184 DISHWASHER, LAMINATE COUNTERTOPS AND FLOORS, MDF WOODEN CABINETS, AND POPCORN CEILING.

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 1051241029 of 06/10/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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