



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

August 30, 2024

Licensee  
Golden Touch Health Care LLC  
6800 Scott Avenue North  
Brooklyn Center, MN 55429

RE: Project Number(s) SL34600015

Dear Licensee:

On August 20, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 30, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess'.

Jess Schoenecker, Supervisor  
State Evaluation Team  
Email: [jess.schoenecker@state.mn.us](mailto:jess.schoenecker@state.mn.us)  
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

June 27, 2024

Licensee

Golden Touch Health Care LLC

6800 Scott Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34600015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **STATE CORRECTION ORDERS**

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

### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

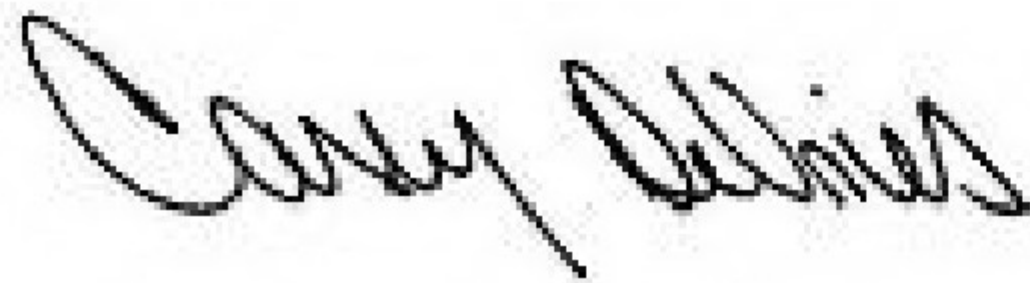
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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



Casey DeVries, Supervisor  
State Evaluation Team  
Email: [Casey.DeVries@state.mn.us](mailto:Casey.DeVries@state.mn.us)  
Telephone: 651-201-5917 Fax: 1-866-890-9290

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Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 000                                                            | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL34600015-0</p> <p>On May 28, 2024, through May 30, 2024, the<br/>Minnesota Department of Health conducted an<br/>initial survey at the above provider, and the<br/>following correction orders are issued. At the time<br/>of the survey, there were three residents, all of<br/>whom were receiving services under the<br/>provider's Assisted Living Facility license.</p> <p>An immediate correction order was identified on<br/>May 29, 2024, issued for SL34600015, tag 0820.</p> <p>On May 30, 2024, the immediacy of correction<br/>order 0820 was removed, however<br/>non-compliance remained, and the scope and<br/>level remained unchanged.</p> | 0 000                                                                                         | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living Facilities. The<br/>assigned tag number appears in the<br/>far-left column entitled "ID Prefix Tag." The<br/>state Statute number and the<br/>corresponding text of the state Statute out<br/>of compliance is listed in the "Summary<br/>Statement of Deficiencies" column. This<br/>column also includes the findings which<br/>are in violation of the state requirement<br/>after the statement, "This Minnesota<br/>requirement is not met as evidenced by."<br/>Following the evaluators ' findings is the<br/>Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |  |                                              |
| 0 480<br>SS=F                                                    | 144G.41 Subd 1 (13) (i) (B) Minimum<br>requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 480                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |  |                                              |
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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 0 480                                                            | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480                                                                                         |                                                                                                                          |  |                                              |
| 0 650<br>SS=F                                                    | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0 650                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| 0 650                                                                   | <p>Continued From page 2</p> <p>contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(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</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-B, ULP-E, and ULP-G).</p> <p>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).</p> | 0 650                                                                                                 |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 0 650                                                            | <p>Continued From page 3</p> <p>The findings include:</p> <p>ULP-B<br/>ULP-B was hired December 26, 2022, to provide direct cares and services to residents.</p> <p>On May 28, 2024, at 11:10 a.m., the surveyor observed ULP-B obtain a blood glucose for R2.</p> <p>ULP-E<br/>ULP-E was hired September 26, 2022, to provide direct cares and services to residents.</p> <p>The licensee's May 2024 schedule indicated ULP-E had worked 3:00 p.m. to 11:00 p.m., on May 27, 2024.</p> <p>ULP-G<br/>ULP-G was hired November 14, 2021, to provide direct cares and services to residents.</p> <p>The licensee's May 2024 schedule indicated ULP-G had worked 11:00 p.m. to 7:00 a.m., on May 17, 2024, and 7:00 a.m. to 3:00 p.m., on May 18, 2024.</p> <p>ULP-B, ULP-E, and ULP-G's employee records lacked an annual performance review for the 2023 year of employment with the licensee.</p> <p>On May 29, 2024, at 10:58 a.m., CNS-A stated they did not know why the previous nurse did not do the performance reviews.</p> <p>The licensee's 4.35 Employee Evaluation policy dated August 1, 2021, read, "All staff of [Licensee] will be given an employee evaluation at least annually."</p> <p>No further information provided.</p> | 0 650                                                           |                                                                                                                          |                          |                                              |

Minnesota Department of Health

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| 0 650                                                            | Continued From page 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 650                                                                                         |                                                                                                                          |  |                                              |
| 0 660<br>SS=F                                                    | <p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(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.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>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 a current facility TB risk assessment.</p> <p>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</p> | 0 660                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 660                                                            | <p>Continued From page 5</p> <p>are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 28, 2024, at 12:35 p.m., clinical nurse supervisor (CNS)-A provided the surveyor with the licensee's TB risk assessment dated August 30, 2022.</p> <p>On May 29, 2024, at 10:54 a.m., CNS-A acknowledged the TB risk assessment had not been completed since August 30, 2022, and stated, "TB Should be done annually, and she [the previous nurse] had on there [written on the top of the August 20, 2024 TB risk assessment worksheet] it needs to be done in August 2024, so that is when we planned to do it."</p> <p>The Licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, read, "the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health."</p> <p>The Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019 dated May 17, 2019, and the CDC guidelines indicate each provider licensed by Minnesota Departement of Health is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening.</p> | 0 660                                                           |                                                                                                                          |                          |                                              |

Minnesota Department of Health

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| 0 660                                                            | Continued From page 6<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 660                                                                                         |                                                                                                                 |  |                                              |
| 0 810<br>SS=F                                                    | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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 | 0 810                                                                                         |                                                                                                                 |  |                                              |

Minnesota Department of Health

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| 0 810                                                            | <p>Continued From page 7</p> <p>drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 30, 2024, at 10:30 a.m., licensed assisted living director (LALD)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN</p> <p>The licensee FSEP dated August 1, 2021, failed to include the following:</p> <p>The FSEP did not identify specific fire protection actions for residents evident by not providing procedures for residents to take during a fire or similar emergency in writing within the FSEP.</p> <p>The FSEP included standard resident evacuation</p> | 0 810                                                           |                                                                                                                          |                          |                                              |

Minnesota Department of Health

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| 0 810                                                            | <p>Continued From page 8</p> <p>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 failed to include evacuation status/ unique and unusual needs of each resident in writing and available in the FSEP.</p> <p>During an interview on May 30, 2024, at 10:45 a.m., LALD-D, stated written procedures for residents during a fire or similar emergency and resident unique needs for evacuation were not included and available in the FSEP.</p> <p>TRAINING</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by providing documentation training was completed once per year for employees and the documentation did not specifically state the training was based on the facility FSEP.</p> <p>During an interview on May 30, 2024, at 11:00 a.m., LALD-D, stated the employee documentation would be sent to survey staff by email. The documentation received by email indicated the employee training was completed one time per year for each employee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 0 810                                                                                         |                                                                                                                 |                    |                                              |
| 0 820<br>SS=H                                                    | <p>144G.45 Subd. 2 (g) Fire protection and physical environment</p> <p>(g) Existing construction or elements, including assisted living facilities that were registered as</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 820                                                                                         |                                                                                                                 |                    |                                              |

Minnesota Department of Health

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| 0 820                                                            | <p>Continued From page 9</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect more than a limited number of residents, staff and visitors.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>Findings include:</p> <p>On a facility tour on May 28, 2024, at 1:00 p.m., with clinical nurse supervisor (CNS)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 1 and 2.</p> | 0 820                                                                                         |                                                                                                                          |  |                                              |

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| 0 820                                                                   | <p>Continued From page 10</p> <p>Occupied Resident Rooms</p> <p>Resident sleeping room number 1, occupied by R3, emergency escape and rescue clear window opening measurements are 23 inches wide, 17 inches in height, and 391 square inches in openable area. The window was measured with CNS-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and clear opening total area.</p> <p>Resident sleeping room number 2, occupied by R2, emergency escape and rescue clear window opening measurements are 25 inches wide, 18.25 inches in height, and 456 square inches in openable area. The window was measured with CNS-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and clear opening total area.</p> <p>It was explained to CNS-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.</p> <p>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches.</p> <p>These deficient conditions were visually verified by CNS-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings.</p> <p>TIME PERIOD FOR CORRECTION: Immediate.</p> <p>Immediacy is removed as confirmed by provider's</p> | 0 820                                                                                                 |                                                                                                                          |  |                                                        |

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| 0 820                                                            | Continued From page 11<br><br>plan of correction on May 30, 2024, at 11:43 a.m., and reviewed by evaluation supervisor on May 30, 2024, at 1:07 p.m., however noncompliance remains at a scope and severity level H.<br><br>Cigarette Butt Disposal<br><br>On the same facility tour on May 29, 2024, at 12:15 p.m., it was observed that used cigarette butts were disposed of outside in the front of the facility near the main door on the ground and main door landing and up close to the building. It was observed there was no cigarette disposal dispenser at the location of the front door where the cigarette butts were disposed of on the ground.<br><br>An appropriate cigarette dispenser near the designated smoking area on the back deck was observed.<br><br>During an interview on May 30, 2024, at 10:30 a.m., licensed assisted living director (LALD)-D, stated used cigarette butts were disposed of outside in the front of the facility near the main door on the ground and main door landing and up close to the building. During the same interview LALD-D, stated an appropriate dispenser would be placed outside near the front main door area and the current practice was not in compliance with the licensee smoking policy.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days. | 0 820                                                                                         |                                                                                                                          |  |                                              |
| 0 950<br>SS=C                                                    | 144G.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 950                                                                                         |                                                                                                                          |  |                                              |

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| 0 950                                                                   | <p>Continued From page 12</p> <p>must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</p> <p>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for two of three residents (R2, R4).</p> <p>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</p> | 0 950                                                                                                 |                                                                                                                          |  |                                                        |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 950                                                            | <p>Continued From page 13</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2's Resident Contract for Assisted Living was signed on July 12, 2022.</p> <p>R2's Resident Contract for Assisted Living paperwork had a spot for Resident's Designated Representative to print and sign their name, and a place for address, phone number and date located on page 20.</p> <p>R4<br/>R4's Resident Agreement was signed on August 1, 2021.</p> <p>R4's Resident Contract for Assisted Living paperwork had a spot for Resident's Designated Representative to print and sign their name, and a place for address, phone number and date located on page 20.</p> <p>R2 and R4's Resident Agreement lacked the designate a representative verbatim "right to designate a representative for certain purposes" notice.</p> <p>On May 29, 2024, at 11:05 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A looked at the statute for designated representative and CNS-A stated, "See [LALD] that is what they need to have and then a spot to sign on its own. We will need to get that done."</p> | 0 950                                                                                         |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN TOUCH HEALTH CARE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6800 SCOTT AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
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| 0 950                                                                   | Continued From page 14<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 950                                                                                                 |                                                                                                                          |  |                                                        |
| 0 970<br>SS=C                                                           | <b>144G.50 Subd. 5</b> Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>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. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2 was admitted to licensee and began receiving assisted living services on July 13, 2022. | 0 970                                                                                                 |                                                                                                                          |  |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 970                                                            | Continued From page 15<br><br>R2's Resident Contract for Assisted Living signed by R2 on July 12, 2022, read, "In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against Landlord and it's representatives for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance coverage such damage or destruction. LIABILITY Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Landlord'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. Landlord 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."<br><br>On May 29, 2024, at 11:00 a.m., during an interview with both licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A, LALD-D stated, "oh, that's in this contract too? We will get it fixed."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 970                                                           |                                                                                                                          |  |                                              |
| 01380<br>SS=F                                                    | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01380                                                           |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 01380                                                            | <p>Continued From page 16</p> <p>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:</p> <p>(1) observing, reporting, and documenting resident status;</p> <p>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;</p> <p>(3) reading and recording temperature, pulse, and respirations of the resident;</p> <p>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;</p> <p>(5) safe transfer techniques and ambulation;</p> <p>(6) range of motioning and positioning; and</p> <p>(7) administering medications or treatments as required.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-B and ULP-E).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B</p> <p>ULP-B was hired on December 26, 2022, to</p> | 01380                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |  |                                              |
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| 01380                                                            | <p>Continued From page 17</p> <p>perform direct care services to the licensee's residents.</p> <p>On May 28, 2024, at 11:02 a.m., the surveyor observed ULP-B provide blood glucose monitoring for R2.</p> <p>ULP-E<br/>ULP-E was hired on September 26, 2022, to perform direct care services to the licensee's residents.</p> <p>The licensee's May 2024 schedule dated May 1, 2024, through May 31, 2024, indicated ULP-E had worked May 1-3, 6-10, 13-17, 20-24, and May 27, 2024.</p> <p>ULP-B and ULP-E's record lacked the following training and competency evaluations:<br/>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and<br/>- recognizing physical, emotional, cognitive, and developmental needs of the resident.</p> <p>On May 29, 2024, clinical nurse supervisor (CNS)-A stated, "Competency trainings are done by the nurse [indicating the previous nurse employed by licensee], I can't speak to why the past nurse doesn't have that training documented and we do not know if it was completed if it was not documented."</p> <p>The licensee's 5.02 Competency Training Evaluations policy, dated August 1, 2021, indicated training done by a nurse on the above-mentioned items would be trained prior to the delegation of services.</p> | 01380                                                           |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 01380                                                            | Continued From page 18<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 01380                                                                                         |                                                                                                                          |  |                                              |
| 01440<br>SS=D                                                    | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for | 01440                                                                                         |                                                                                                                          |  |                                              |

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| 01440                                                            | <p>Continued From page 19</p> <p>one of three employees (ULP-B).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B was hired on December 26, 2022, to perform direct care services to the licensee's residents.</p> <p>On May 28, 2024, at 11:02 a.m., the surveyor observed ULP-B provide blood glucose monitoring for R2.</p> <p>ULP-B's record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks.</p> <p>On May 29, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-A stated they did not know why the previous nurse did not do the 30 day supervision.</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, read, "direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance."</p> | 01440                                                                                         |                                                                                                                          |  |                                              |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01440                                                            | Continued From page 20<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01440                                                                                         |                                                                                                                          |  |                                              |
| 01500<br>SS=F                                                    | 144G.63 Subd. 5 Required annual training<br><br>(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:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning | 01500                                                                                         |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01500                                                            | <p>Continued From page 21</p> <p>and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(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:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-B, ULP-E, and ULP-G) reviewed.</p> <p>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</p> | 01500                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |  |                                              |
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| 01500                                                            | <p>Continued From page 22</p> <p>has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B<br/>ULP-B was hired on December 26, 2022, to perform direct care services to the licensee's residents.</p> <p>On May 28, 2024, at 11:02 a.m., the surveyor observed ULP-B provide blood glucose monitoring for R2.</p> <p>ULP-E<br/>ULP-E was hired on September 26, 2022, to perform direct care services to the licensee's residents.</p> <p>ULP-G<br/>ULP-G was hired on November 14, 2021, to perform direct care services to the licensee's residents.</p> <p>ULP-B, ULP-E and ULP-G's employee records lacked evidence annual training had been completed as required in the following areas:</p> <ul style="list-style-type: none"><li>- reporting maltreatment of vulnerable adults;</li><li>- assisted Living Bill of Rights;</li><li>- effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</li><li>- review of provider's policies and procedures; and</li><li>- principles of person-centered planning/service delivery.</li></ul> <p>On May 29, 2024, at 10:57 a.m., clinical nurse</p> | 01500                                                           |                                                                                                                          |  |                                              |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34600</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/30/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN TOUCH HEALTH CARE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6800 SCOTT AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
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| 01500                                                                   | Continued From page 23<br><br>supervisor (CNS)-A stated they thought the trainings were covered in Educare (training software) and would need to look into it.<br><br>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff providing services to residents would complete eight hours of education for every twelve months of employment, and would cover the above-mentioned topics.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01500                                                                                                 |                                                                                                                          |  |                                                        |
| 01540<br>SS=F                                                           | <b>144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED</b><br><br>(3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 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;<br><br>This MN Requirement is not met as evidenced | 01540                                                                                                 |                                                                                                                          |  |                                                        |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |  |                                              |
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| 01540                                                            | <p>Continued From page 24</p> <p>by:<br/>Based on observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-B, ULP-E, and ULP-G) completed the required amount of dementia care training in the required time frame.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B<br/>ULP-B was hired on December 26, 2022, to perform direct care services to the licensee's residents.</p> <p>On May 28, 2024, at 11:02 a.m., the surveyor observed ULP-B provide blood glucose monitoring for R2.</p> <p>ULP-B employee file contained initial dementia Educare training (an electronic training software) and one hour of annual dementia training but lacked the two hours of annual training hours needed for dementia training.</p> <p>ULP-E<br/>ULP-E was hired on September 26, 2022, to perform direct care services to the licensee's residents.</p> | 01540                                                           |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 01540                                                            | Continued From page 25<br><br>ULP-G<br>ULP-G was hired on November 14, 2021, to perform direct care services to the licensee's residents.<br><br>ULP-E and ULP-G's employee file contained initial dementia Educare training but lacked any annual training hours on dementia.<br><br>On May 29, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-A stated they thought the trainings were covered in Educare and would need to look into it.<br><br>The licensee's 5.03 Dementia Training policy, dated August 1, 2021, read, "All staff will complete two (2) hours of additional training for each 12 months of work thereafter."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 01540                                                                                         |                                                                                                                          |  |                                              |
| 01620<br>SS=F                                                    | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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                                                                               | 01620                                                                                         |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 01620                                                            | <p>Continued From page 26</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessments, not to exceed 90 calendar days from the last date of assessment and failed to ensure the RN completed ongoing resident reassessments to include all areas required on the uniform assessment tool for two of two residents (R2, R4) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R2<br/>R2 was admitted to the licensee and began receiving services on July 13, 2022.</p> | 01620                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| 01620                                                            | <p>Continued From page 27</p> <p>R2's diagnoses included anxiety, depressive disorder, diabetes, and schizophrenia.</p> <p>R2's Signed Care Plan form dated July 13, 2022, indicated R2 received assistance with dressing, grooming, bathing, food preparation, weekly vitals, and medication administration.</p> <p>R2's record indicated the RN completed a nurse assessment visit form that indicated a choice for the nurse to select no change or not assessed for the areas assessed on February 2, 2023, May 11, 2023, and August 15, 2023, which exceeded the 90 calendar days from the last assessment by 98 days, 96 days and 287 days, respectively. The licensee was unable to produce an assessment that indicated the baseline for R2 in order to show what the no change was from. In addition, ongoing assessments lacked the following areas required on a uniform assessment tool per MN Rules Chapter 4659.0150:</p> <ul style="list-style-type: none"><li>- the resident's personal lifestyle preferences;</li><li>- activities of daily living;</li><li>- physical health status;</li><li>- nutritional and hydration status and preferences;</li><li>- list of treatments; and</li><li>- risk indicators.</li></ul> <p>R4</p> <p>R4 was admitted to the licensee and began receiving services on August 7, 2020.</p> <p>R4's diagnoses included ADHD, anxiety. Aspergers syndrome, gender dysphoria in adult major depressive disorder.</p> <p>R4's Signed Service Plan form dated October 24, 2021, indicated R4 received assistance with oral hygiene, grooming, bathing, housekeeping, linen</p> | 01620                                                           |                                                                                                                          |  |                                              |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                            | <p>Continued From page 28</p> <p>changes, laundry, daily vitals, medication reminders, and medication administration.</p> <p>R4's record indicated the RN completed a nurse assessment visit form that indicated a choice for the nurse to select no change or not assessed for the areas assessed on May 22, 2023, November 30, 2023, and March 1, 2024, which exceeded the 90 calendar days from the last assessment by 192 days and 91 days, respectively. The licensee was unable to produce an assessment that indicated the baseline for R2 in order to show what the no change was from. In addition, ongoing assessments lacked the following areas required on a uniform assessment tool per MN Rules Chapter 4659.0150:</p> <ul style="list-style-type: none"><li>- the resident's personal lifestyle preferences;</li><li>- activities of daily living;</li><li>- physical health status;</li><li>- nutritional and hydration status and preferences;</li><li>- list of treatments; and</li><li>- risk indicators.</li></ul> <p>On May 29, 2024, at 11:07 a.m. clinical nurse supervisor (CNS)-A indicated they did not have knowledge of why or how the previous nurse had completed assessments and stated, "We should be reassessing every 90 days and any change in condition and show what has happened within those three months."</p> <p>The licensee's 6.01 Assessments, Reviews &amp; Monitoring policy, dated August 1, 2021, read, "The initial nursing assessment and reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment."</p> | 01620                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN TOUCH HEALTH CARE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6800 SCOTT AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                    |  |                                                     |
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| 01620                                                                   | Continued From page 29<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 01620                                                                  |                                                                                                                          |  |                                                     |
| 01650<br>SS=D                                                           | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by: | 01650                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |                          |                                              |
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| 01650                                                            | <p>Continued From page 30</p> <p>Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted to licensee and began receiving assisted living services on July 13, 2022.</p> <p>R2 diagnoses included anxiety, depressive disorder, diabetes, and schizophrenia.</p> <p>R2's signed service plan dated July 13, 2022, lacked information and a method to contact the facility.</p> <p>On May 29, 2024, at 10:49 a.m., clinical nurse supervisor (CNS)-A stated, "I have no idea [why the service plan was missing information] but we will update it."</p> <p>The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated all required content would be included in the service plan per 144G.70 subd. 4.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 01650                                                           |                                                                                                                          |                          |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |                          |                                              |
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| 01910<br>SS=D                                                    | <p>144G.71 Subd. 22 Disposition of medications</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1).</p> <p>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</p> | 01910                                                           |                                                                                                                          |                          |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 01910                                                            | <p>Continued From page 32</p> <p>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).</p> <p>The findings include:</p> <p>R1 was discharged from the licensee to another assisted living facility on December 7, 2023.</p> <p>R1's record lacked a medication disposition to include 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.</p> <p>On May 28, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated, "Here is what I have for [R1] I believe he was discharged to another house [different assisted living facility], and all the medications were sent with to the other house. I wasn't here when this happened, but this is all I could find for the discharge records."</p> <p>The licensee's 7.23 Medication Disposal policy dated August 1, 2021, read, "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."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p> | 01910                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN TOUCH HEALTH CARE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6800 SCOTT AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
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| 02290                                                                   | Continued From page 33                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 02290                                                                                                 |                                                                                                                          |  |                                                        |
| 02290<br>SS=D                                                           | <p>144G.91 Subd. 2 Legislative intent</p> <p>The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee established written house rules and regulations that used language which limited the rights of one of two residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted to licensee and began receiving assisted living services on July 13, 2022.</p> <p>R2 diagnoses included anxiety, depressive disorder, diabetes, and schizophrenia.</p> <p>On May 28, 2024, at 11:40 a.m., while reviewing R2's resident file, surveyor observed the licensee's House Rules and Regulations form signed by R2 on July 13, 2022.</p> | 02290                                                                                                 |                                                                                                                          |  |                                                        |

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| 02290                                                            | Continued From page 34<br><br>The Licensee's House Rules and Regulations read,<br>"1, All residents shall be familiar with the House Rules along with Fire and Safety Procedures.<br>2. Absolutely no alcohol will be permitted while you are a resident of the [Licensee]. This applies at all times including when you are away from the [Licensee]. This applies to the usage of drugs and possession of drug paraphernalia. Violations of this will result in immediate Discharge. This same rule applies to visitors and relatives.<br>3. All prescription medications will be turned over to the Staff for safekeeping and proper administration. Non-prescription medications must be turned into the Staff and will be kept by the Staff.<br>4. Residents are subject to random Drug and Alcohol tests at any time if the House Manager decides to test. Failure of these tests or refusal of these tests will result in immediate discharge from the Home.<br>5. The House Manager and Staff reserve the right to perform a room search at any time it is deemed necessary to insure the serenity and security of the Home. This includes personal items and vehicles if appropriate.<br>6. Threats or acts of violence toward the Staff or other Residents will not be tolerated and may result in immediate discharge and prosecution according to the Law.<br>7. No Firearms, hunting knives or other weapons are permitted by the residents of the Home. Any of these should be turned over to the staff and will be locked in a safe place.<br>8. Smoking inside the [Licensee] is NOT PERMITTED and will result in immediate discharge. Smoking is permitted in the smoking area out back of the [Licensee] until 9pm unless otherwise approved by the House Manager.<br>Smoking rules must always be followed. No | 02290                                                                                         |                                                                                                                          |  |                                              |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                            |  |                                              |
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| 02290                                                            | Continued From page 35<br><br>resident will borrow or loan cigarette to other resident.<br>9. You must always respect the rights of the other residents. Each resident will be given a fair and equal opportunity to continue living at the Home.<br>10. Gambling is strictly prohibited, including the purchase of Lottery Tickets.<br>11. No resident will borrow or loan money to other residents.<br>12. Any resident that has access to a vehicle may bring their vehicle to the Home after 30 days if they are working, or after 60 days if not. This is at the discretion of the House Manager.<br>13. House curfew is 9:30PM every night. The doors will be locked at that time. Unless approved by the staff, any resident returning after 9:30pm must find other sleeping arrangements for the night. Failure to return before curfew will result in discharge from the Home if [sic] happens THREE TIMES IN THE SAME MONTH.<br>14. All residents must use the "sign in/out sheet" when leaving the property. This must be done to ensure that the staff knows where residents are always.<br>15. All residents must live at the Home for 3 days before they can sign themselves out. Each resident will become, at the House Managers discretion, eligible for a 3-power pass on their free days. (RESIDENT MUST HAVE DOCTOR'S ORDER FOR "LOA")<br>16. All residents must live at the Home for thirty days before they can become eligible for an overnight or weekend pass. This time period may be waived by the House Manager for emergencies and special circumstances. No more than 2 days passes per month will be approved unless there is a reasonable reason for the House Manager to consider. Should an emergency arise that prevents you from returning on specified date or time, you must contact the | 02290                                                           |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34600                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/30/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN TOUCH HEALTH CARE LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6800 SCOTT AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
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| 02290                                                            | Continued From page 36<br><br>staff or immediately. [sic] passes must be filled out by Wed at noon of the week requested. Failure to abide by these rules will result in discharge from the Home.<br>17. All visitors are subject to the approval by Staff. No visitors are permitted on the property while under the influence of alcohol or drugs. No visitor is allowed in the house before 9am or after 9pm.<br>19. [sic] All residents are to assist in keeping the Home and surrounding grounds neat and clean. This includes daily assigned chores, special work assignments and your own room. Beds that will be made daily and chores completed as scheduled.<br>20. If a resident goes to work, they are still responsible for their chores. The responsibility of the chore being done will fall upon the resident originally assigned the chore.<br>21. All food and snack items will be eaten in the dining room. No eating in the bedrooms, television lounge or smoking area. No drinks other than water may be taken to resident's room at any time.<br>22. All residents will be responsible for keeping the kitchen clean. All dishes must be washed using hot, soapy water and must be air dried.<br>23. Residents must be fully clothed (including shoes) and are also expected to maintain good hygiene and personal cleanliness. This includes taking a shower daily or as scheduled.<br>24. Laundry is to be done during assigned times unless approved by staff. No resident will put laundry in and leave the premises. Lint filters will be cleaned after each load. At no time, will laundry be done after 6pm unless approved by the Staff.<br>25. No resident is to enter another resident's room without the other resident being there.<br>26. Residents will keep the volume of their radios | 02290                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| 02290                                                            | <p>Continued From page 37</p> <p>at a level not to be heard in the hallways. Failure to do so will result in loss of this privilege. Headphones must be used after 11:00pm.</p> <p>27. There will be no nude or partially nude pictures on the walls of the resident's rooms.</p> <p>28. When discharged from the Home, all personal effects must be removed immediately. The Home will not accept responsibility for items that have been left. The home will make every effort to protect personal items and will hold items for 10 days (without assuming responsibility) to give time for the resident to make arrangements to pick them up. After 10 days, items will be donated to local mission and will not be stored at the Home. Valuables may be turned over to the staff for safekeeping.</p> <p>29. The House Manager of the Homes has the final decision as to whether a resident is following the rules and whether the residents can remain at the Home. Every effort will be made to ensure that the resident understands the rules and is complying with the rules of the Home before resident is discharged.</p> <p>30. If a resident has a grievance against the Home, another client, and/or a staff member there is a grievance policy form for you to fill out and give to the House Manager."</p> <p>Page four of the House Rules and Regulations went on to read, "Smoke breaks will be given at the following times: (times are subject to change)</p> <p>MORNING Between 9:00 a.m. - 9:30 a.m.<br/>Between 11:00 a.m. - 11:30 a.m. AFTERNOON<br/>Between 1:30 p.m. - 2:00 p.m. Between 4:30 p.m. - 5:00 p.m. EVENING Between 7:30 p.m. - 8p.m<br/>Between 8:30 p.m. - 9 p.m. Residents will not be allowed to smoke before or after the scheduled time."</p> <p>On May 29, 2024, at 10:43 a.m. licensed assisted living director (LALD)-D stated, "I know they are</p> | 02290                                                                                         |                                                                                                                          |  |                                              |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN TOUCH HEALTH CARE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6800 SCOTT AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
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| 02290                                                                   | <p>Continued From page 38</p> <p>allowed to smoke outside anytime just not inside, I have not experienced that other stuff (house rules) before, so ok we will need to fix that." LALD-D indicated they did not know who put those house rules into effect as they just took over as LALD on May 13, 2024.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 02290                                                                                                 |                                                                                                                          |  |                                                        |

Type: Full  
Date: 05/29/24  
Time: 14:14:43  
Report: 1021241144

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Golden Touch Health Care Llc  
6800 Scott Avenue North  
Brooklyn Center, MN55429  
Hennepin County, 27

**Establishment Info:**

ID #: 0037973  
Risk:  
Announced Inspection: Yes

**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.

### 4-300 Equipment Numbers and Capacities

#### 4-302.12B **\*\* Priority 2 \*\***

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

FOOD THERMOMETER ON-SITE IS A THICK DIAL THERMOMETER. PROVIDE A DIGITAL THIN PROBE THERMOMETER AS DESCRIBED IN RULE ABOVE.

*Comply By: 06/05/24*

### 2-100 Supervision

#### 2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

WAS ABLE TO VERIFY THAT ESTABLISHMENT HAS A CERTIFIED FOOD PROTECTION MANAGER (CFPM) BUT IT WAS NOT POSTED. POST CFPM ON-SITE.

*Comply By: 06/03/24*

### 6-500 Physical Facility Maintenance/Operation and Pest Control

#### 6-501.12A

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

THE GLASS DOME COVERING THE KITCHEN CEILING LIGHT FIXTURE CONTAINS ACCUMULATION OF DEBRIS. CLEAN AND MAINTAIN CLEAN.

*Comply By: 06/03/24*

### Food and Equipment Temperatures

Type: Full  
Date: 05/29/24  
Time: 14:14:43  
Report: 1021241144  
Golden Touch Health Care Llc

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding  
Temperature: 38 Degrees Fahrenheit - Location: MILK - KENMORE REFRIGERATOR  
Violation Issued: No

Process/Item: Ambient Temperature  
Temperature: 36 Degrees Fahrenheit - Location: KENMORE REFRIGERATOR  
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD/FOOD MANAGER, MICHAEL NORNIE AND HEALTH REGULATION DIVISION NURSE EVALUATOR, TESA BROWN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH HOUSE MANAGER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, VINYL FLOORS AND POPCORN CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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

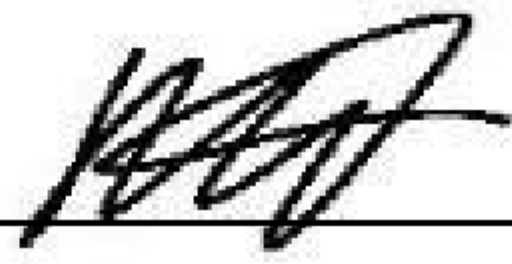
I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241144 of 05/29/24.

Certified Food Protection Manager MICHAEL G. NORNIE

Certification Number: FM111585 Expires: 03/22/25

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_  
MICHAEL NORNIE  
LALD/FOOD MANAGER

Signed:  \_\_\_\_\_  
Melissa Ramos  
Environmental Health Specialist  
Metro District Office  
651-201-4495  
Melissa.Ramos@state.mn.us