Electronically Delivered

July 26, 2024

Licensee
Goldies Group Homes LLC
5390 West Old Shakopee Circle
Bloomington, MN 55437

RE: Project Number(s) SL39238015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 26, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39238	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDIES GROUP HOMES LLC	5390 WEST OLD SHAKOPEE CIRCLE BLOOMINGTON, MN 55437

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39238015-0 On June 25, 2024, through, June 26, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the provider's provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to obtain accurate licensure when they applied for licensure for a assisted living facility, despite sharing one roof with adjoining family home, without having evidence of an approved two-hour fire barrier wall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 26, 2024, at 12:30 p.m. engineering staff toured the facility with owner/house manager (O/HM)-A. The facility was located in one half of a side-by side duplex home (a housing configuration that allows for two separate residential units within one structure). The engineer was able to confirm a block wall between the two garages, but was unable to confirm the construction of the walls and ceiling between the building's dwelling space. The engineer stated that assisted living licensing, requires the wall separating licensed assisted living facilities from another licensed facility or another occupancy in the same building, to be constructed as a 2-hour fire barrier wall. O/HM-A was unable to provide evidence two-hour fire walls existed between the two dwellings. The	0 100		

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0 100	Continued From page 3 engineer advised O/HM-A she would need to consult with a building official or an architect for verification and provide to the engineer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 100		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee developed and implemented a staffing plan for determining its staffing levels. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. the surveyor requested a copy of the licensee's staffing plan. Owner/house manager (O/HM)-A stated one direct care staff was scheduled each 12-hour shift (7:00 a.m. - 7:00 p.m., and 7:00 p.m. - 7:00 a.m.). O/HM-A stated they posted the staff schedule but did not have a formal staffing plan. The licensee's 2.15 Staffing policy dated November 3, 2022, indicated: The clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 5 (21) Days.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 25, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=C	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 6 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (owner/house manager (O/HM)-A, clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-D). 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).	0 650		

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0 650	Continued From page 7 The findings include: O/HM-A had a start date of June 6, 2022. CNS-B had a start date of September 28, 2023. ULP-D had a start date of June 2, 2023. O/HM-A, CNS-B, and ULP-D's records lacked evidence of the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision On June 26, 2024, at 4:05 p.m. O/HM-A stated she did not include a job description in any of the employee files. The licensee's 4.9 Personnel Records policy dated November 3, 2022, indicated: 1. A personnel record will be started for each staff member upon hire. 3. A job description is maintained that includes qualifications, responsibilities and identifications of supervisors for each job classification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 8 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's TB risk assessment dated August	0 660		

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0 660	Continued From page 9 9, 2023, indicated the licensee was a low risk. CNS-B CNS-B had a start date of September 28, 2023. CNS-B's employee file included a one-step TST placed September 22, 2023, and read on September 25, 2023. CNS-B's file did not include evidence a second-step TST had been completed. ULP-D ULP-D had a start date of June 2, 2023. ULP-D's employee file included a one-step TST placed April 6, 2023, and read on April 9, 2023. ULP-D's file did not include evidence a second-step TST had been completed. On June 26, 2024, at 4:05 p.m. O/HM-A stated CNS-B and ULP-D had only completed a one-step TST and was not aware of the requirement to complete a second step. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB).	0 660		

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0 660	Continued From page 10 An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's 4.14 Tuberculosis Screening/Prevention policy dated November 3, 2022, indicated: 1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 2. Baseline screening includes as assessment for TB history and current TB symptoms. 3. An employee's history of BCG vaccination will be disregard when administering and interpreting TST results. 4. The baseline test may be either TST (2-step) or BAMT (blood assay for M. tuberculosis). 5. If the first-step TST is negative, the second-step TST will be administered 1-3 weeks after the first TST result was read. 6. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis. Additional TB screening is not necessary unless an exposure to M. tuberculosis occurs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 11 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on June 26, 2024, at 11:45 a.m., with owner/house manager (O/HM)-A, survey staff observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual inspections had been performed as required. Annual inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order.	0 790		

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	39238	A. BUILDING: _____ B. WING _____	06/26/2024

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0 790	Continued From page 12 O/HM-A verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 13 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 26, 2024, at 12:07 p.m., owner/house manager (O/HM)-A provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have complete employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation	0 810		

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0 810	Continued From page 14 during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan needs to be updated to the facility's current setup. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. O/HM-A was going to email these documents as they were filed electronically and could not be retrieved upon the survey. I did not receive an email of these documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 15 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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01060	Continued From page 16 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's unsigned service plan printed June 25, 2024, indicated R1 received services which included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. R1's After Visit Summary dated June 2, 2024, indicated R3 had been hospitalized from June 2, 2024, until June 14, 2024. R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care the	01060		

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01060	Continued From page 17 resident had been relocated and had not returned to the facility within four days. On June 25, 2024, at 3:30 p.m. owner/house manager (O/HM)-A stated the licensee had not provided a written relocation notice to R1 when hospitalized nor was the Office of Ombudsman for Long-Term Care notified when R1 had not returned within four days. CNS-B further stated being unaware of the requirement. The licensee's 5.1 Discharge and Transfer of Residents policy dated November 3, 2022, indicated: 25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of emergency relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to the licensee within four (4) days, the Office of Ombudsman for Long-Term Care f. Notice of the right to appeal the decision under 144G.54 26. The written notice shall include the following: a. The reason for the relocation b. Name and contact information for the location to which the resident has been located and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities d. If known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not	01060		

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01060	Continued From page 18 currently known e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included bronchiectasis (a lung condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. R1's unsigned, service plan printed June 25, 2024, included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. R1's record included a 14-day assessment dated June 18, 2023. R1's next assessment was dated September 18, 2023; 92 days had passed between assessments (two days late). On June 25, 2024, at 3:30 p.m. owner/house manager (O/HM)-A and clinical nurse supervisor (CNS)-B reviewed R1's assessments and stated the first 90-day assessment had been conducted	01620		

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01620	Continued From page 20 late. The licensee's 2.3 Assessment and Reassessment policy dated November 3, 2022, indicated: 7. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. 8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 21 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised and signed by the resident to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. owner/house manager (O/HM)-A stated clinical nurse supervisor (CNS)-B set-up R1's medications weekly in a medi-minder; all medications were secured in a locked cabinet. On June 26, 2024, at 8:07 a.m. O/HM-A was observed assisting R1 with his prescribed nebulizer treatment. O/HM-A assisted R1 with applying the attachments to the nebulizer machine and adding the medication. O/HM-A then handed the attached apparatus with the medication to R1 who then administered independently. R1's diagnoses included bronchiectasis (a lung	01640		

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01640	Continued From page 22 condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. R1's unsigned service plan printed June 25, 2024, included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. The service plan did not include medication administration. On June 25, 2024, at 3:30 p.m. O/HM-A stated they had resident's sign the initial service plan but did not obtain a signature with any revisions. On June 25, 2024, at 3:52 p.m. CNS-B stated having removed medication administration and set-up from R1's service plan as the resident had documentation from his providers that he could manage his own medications. CNS-B stated the licensee still provided secure storage for the medications and she also set them up weekly in a medi-minder with R1 present. Staff provided the medications to the resident for administration and watched him consume all but the nebulizer medications. O/HM-A stated prior to R1 coming to the facility he had been managing all his own medications and had a difficult time giving that up when first coming to the assisted living. O/HM-A further stated the process they had in place now was working well. On June 26, 2024, at 9:28 a.m. R1 stated staff set-up and administered his medications, and sometimes would assist with setting up his nebulizer, though he could do it himself. The licensee's 1.7 Service Plan policy dated November 3, 2022, indicated: 4. The initial service plan and any revisions are signed by a representative from the licensee and	01640		

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01640	Continued From page 23 the resident or resident's representative, indicating agreement with the services to be provided. 8. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 24 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. owner/house manager	01730		

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01730	Continued From page 25 (O/HM)-A stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included bronchiectasis (a lung condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. R1's unsigned, service plan printed June 25, 2024, included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. The service plan did not include medication administration. R1's After Visit Summary discharge orders dated June 14, 2024, included an order for ipratropium-albuterol 0.5 mg (milligrams)/ 2.5 mg/3 ml (milliliters) neb solution. Take one vial by nebulization four times daily. On June 26, 2024, at 8:07 a.m. O/HM-A was observed assisting R1 with his prescribed nebulizer treatment. R1 was seated in a chair in his room with a side table next to it; his nebulizer machine was on top of the table and the medication was stored within the unlocked drawer of the table. R1 stated they kept the medications stored in the drawer, so the staff didn't have to run up and down the stairs all the time to retrieve the meds. O/HM-A assisted R1 with applying the attachments to the nebulizer machine and adding the medication. O/HM-A then handed the attached apparatus with the medication to R1 who then administered independently. R1's most recent assessment by the registered nurse (RN) dated June 25, 2024, was reviewed. The assessment included an assessment of R1's medications and an individualized medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39238	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDIES GROUP HOMES LLC	5390 WEST OLD SHAKOPEE CIRCLE BLOOMINGTON, MN 55437

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01730	Continued From page 26 management plan. The assessment indicated: Controlled medications are counted and double locked. All other medications are locked in the medication cabinet. The assessment further indicated self-administration of medications was not applicable. On June 26, 2024, at 11:03 a.m. clinical nurse supervisor (CNS)-B reviewed R1's current medication management assessment/plan and stated it was inaccurate related to storage of R1's nebulizer medication and his ability to self-administer his nebulizer medication. The licensee's 3.6 Storage/Control of Medications policy dated November 3, 2022, indicated: 14. Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 27 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document medication administration as prescribed for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. owner/house manager (O/HM)-A stated clinical nurse supervisor (CNS)-B set-up R1's medications weekly in a medi-minder; all medications were secured in a locked cabinet. Staff were responsible for providing the medications to R1 as ordered and he would take them independently. On June 26, 2024, at 8:07 a.m. O/HM-A was observed assisting R1 with his prescribed nebulizer treatment. O/HM-A assisted R1 with applying the attachments to the nebulizer machine and adding the medication. O/HM-A then handed the attached apparatus with the medication to R1 who then administered independently.	01760		

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01760	Continued From page 28 R1's diagnoses included bronchiectasis (a lung condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. R1's unsigned, service plan printed June 25, 2024, included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. The service plan did not include medication administration. On June 25, 2024, at 3:52 p.m. CNS-B stated having removed medication administration and set-up from R1's service plan as the resident had documentation from his providers that he could manage his own medications. CNS-B stated the licensee still provided secure storage for the medications and she also set them up weekly in a medi-minder with R1 present. Staff provided the medications to the resident for administration and watched him consume all but the nebulizer medications. O/HM-A stated prior to R1 coming to the facility he had been managing all his own medications and had a difficult time giving that up when first coming to the assisted living. O/HM-A further stated the process they had in place now was working well. On June 26, 2024, at 9:28 a.m. R1 stated staff set-up and administered his medications, and sometimes would assist with setting up his nebulizer, although he could do it himself. On June 26, 2024, at 2:26 p.m. the surveyor and O/HM-A reviewed R1's Service Recap Summary dated June 2024. O/HM-A stated staff had not been documenting medication administration for R1 as he was considered to be "self-administering" his medications.	01760		

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01760	Continued From page 29 The licensee's 3.5 Medication Documentation policy dated November 3, 2022, indicated: 1. Complete documentation of medication administration includes the following a. Resident's name b. Medication name c. Mediation dosage d. Date and time of administration e. Method/route of administration f. Signature and Title of staff administering the medication 4. Documentation of medication administration and medication set up will be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for the licensee's one resident (R1). This practice resulted in a level two violation (a	01770		

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01770	Continued From page 30 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. owner/house manager (O/HM)-A stated clinical nurse supervisor (CNS)-B set-up R1's medications weekly in a medi-minder; all medications were secured in a locked cabinet. Staff were responsible for providing the medications to R1 as ordered, and he would take them independently. During the facility tour on June 25, 2024, at 12:35 a.m. the surveyor observed the locked medication storage cupboard with O/HM-A. R1's medications were observed in the locked cabinet along with a separate lockbox to secure narcotic medications. The surveyor did not observe a medi-minder for R1 in the locked cabinet. O/HM-A stated they kept those medications along with his inhalers, prescription cream, and eye drops in the front closet (medications for that day). O/HM-A showed the surveyor the closet with a sign on it indicating "Employees Only", which was not locked. The surveyor observed R1's medi-minder containing scheduled oral medications set-up for the week, along with his prescription cream, inhaler, and eye drops. The surveyor explained to O/HM-A that all medications needed to be secured at all times. O/HM-A then removed the medications from the unlocked closet and placed into the locked medication cabinet.	01770		

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01770	Continued From page 31 R1's diagnoses included bronchiectasis (a lung condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. R1's unsigned, service plan printed June 25, 2024, included assistance with dressing, bathing, grooming, transfers, ambulation, laundry, and housekeeping. The service plan did not include medication administration. On June 25, 2024, at 3:52 p.m. CNS-B stated having removed medication administration and set-up from R1's service plan as the resident had documentation from his providers that he could manage his own medications. CNS-B stated the licensee still provided secure storage for the medications and she also set them up weekly in a medi-minder with R1 present. CNS-B stated she had not been documenting the weekly set-up of R1's scheduled oral medications. On June 26, 2024, at 9:28 a.m. R1 stated staff set-up and administered his medications, and sometimes they would assist with setting up his nebulizer, although he could do it himself. The licensee's 3.5 Medication Documentation policy dated November 3, 2022, indicated: 3. The licensee will document medication set up according to the following: a. Date of medication setup b. Name of medication c. Quantity of dose d. Times to be administered e. Route of administration f. Name/title of person completing medication setup 4. Documentation of medication administration	01770		

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01770	Continued From page 32 and medication set up will be completed promptly. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included bronchiectasis (a lung condition where your airways get damaged and widen, making it hard to clear mucus and prone to infections) and congestive heart failure. During the entrance conference on June 25,	01880		

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01880	Continued From page 33 2024, at 11:28 a.m. owner/house manager (O/HM)-A stated clinical nurse supervisor (CNS)-B set-up R1's medications weekly in a medi-minder; all medications were secured in a locked cabinet. Staff were responsible for providing the medications to R1 as ordered, and he would take them independently. During the facility tour on June 25, 2024, at 12:35 a.m. the surveyor observed the locked medication storage cupboard with O/HM-A. R1's medications were observed in the locked cabinet along with a separate lockbox to secure narcotic medications. The surveyor did not observe a medi-minder for R1 in the locked cabinet. O/HM-A stated they kept those medications along with his inhalers, prescription cream, and eye drops in the front closet (medications for that day). O/HM-A showed the surveyor the closet with a sign on it indicating "Employees Only", which was not locked. The surveyor observed R1's medi-minder containing scheduled oral medications set-up for the week, along with his prescription cream, inhaler, and eye drops. The surveyor explained to O/HM-A that all medications needed to be secured at all times. O/HM-A then removed the medications from the unlocked closet and placed into the locked medication cabinet. The licensee's 3.6 Storage/control of Medications policy dated November 3, 2022, indicated: 14. Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for the licensee's one resident (R1) with a bed rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 25, 2024, at 11:28 a.m. clinical nurse supervisor (CNS)-B stated R1 had a hospital bed with rails. CNS-B stated she had assessed the bed for safety, but this did not include measurements of the bed rails. On June 25, 2024, at 3:40 p.m. the surveyor observed R1's room. R1 was sleeping in bed on top of the covers, and the surveyor was unable to visualize the bed had rails as the comforter was covering the sides of the bed.	02310		

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02310	Continued From page 35 R1's diagnoses included bronchiectasis and congestive heart failure. R1's unsigned, Service Plan printed June 25, 2024, indicated R1 received services including activity assistance, ambulation, bathing, grooming, dressing, transfers, respiratory equipment care, housekeeping, and laundry. On June 26, 2024, at 9:28 a.m. R1 was observed seated on his bed in his room; the bed had bilateral hospital rails in the down position. R1 stated the bedrails "stayed down" and he did "not use them." R1's medical record did not include evidence of a bedrail assessment. On June 26, 2024, at 11:03 a.m. CNS-B stated she had not completed an assessment on R1's bedrails, and was unaware she needed too. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual	02310		

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02310	Continued From page 36 is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 2.8 Side Rail Use policy indicated: 11. The RN (registered nurse) will verify that the side rails meet FDA guidelines and follow the manufacturer's recommendation related to the	02310		

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02310	Continued From page 37 following: The side rails, mattress and bed frame are compatible The side rails are appropriate for the age, size and weight of the resident The side rails are securely installed or attached to the bed frame according to the manufacturer's recommendations for the particular bed frame and side rails used The manufacturer's guidelines should be accessible As indicated, additional information will be obtained from the Consumer Product Safety Commission (CSPC) related to side rails and any recalls No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/25/24*
Time: 11:23:09
Report: 1050241121

Food and Beverage Establishment Inspection Report

Location:
Goldies Group Homes LLC
5390 West Old Shakopee Circle
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0042170
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #: 6127470644
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

FACILITY DOES NOT HAVE A CURRENT ILLNESS LOG POSTED. DISCUSSED THE IMPORTANCE AND PROVIDED LOG AND FACT SHEETS VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 06/26/24

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

FACILITY DOES NOT HAVE CLEAN UP KIT ON SITE. DISCUSSED TEMPORARY SOLUTION OF BLEACH AND WATER UNTIL KIT HAS BEEN PROVIDED. COMPLY WITH RULE ABOVE.

Comply By: 07/12/24

Surface and Equipment Sanitizers

Hot Water: = at 180F Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Type: Full
Date: *06/25/24*
Time: 11:23:09
Report: 1050241121
Goldies Group Homes LLC

Food and Beverage Establishment Inspection Report

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

Inspection was completed by MDH Andrew Spaulding and Sagal. Wendy Buckholz was the lead Health Regulation Division Nurse Evaluator. Facility had one resident on site at time of inspection. Meals are prepared on site.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition.

Refrigerator work order was placed due to it not keeping temperatures. All Items were removed prior to inspection by operator. Instructed operator not place food items back inside until refrigerator was fixed.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 1050241121 of 06/25/24.

Certified Food Protection Manager Sagal A. Blomgren

Certification Number: FM115845 Expires: 01/09/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sagal A. Blomgren
Operator

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
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