Electronically Delivered

September 25, 2025

Licensee
Golden Valley Residence
1940 Major Drive
Golden Valley, MN 55422

RE: Project Number(s) SL24264016

Dear Licensee:

On July 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 25, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 25, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 25, 2025, found not corrected at the time of the July 23, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0630 - Compliance With Requirements For Reporting Ma - 144g.42 Subd. 6 (b) - $500.00
0650 - Staff Records - 144g.42 Subd. 8 (a) - $500.00
0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
1350 - Temporary Staff - 144g.60 Subd. 5 - $500.00
1460 - Orientation Of Staff And Supervisors - 144g.63 Subdivision 1 - $500.00
1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E) - $500.00
1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E) - $500.00
1700 - Provision Of Medication Management Services - 144g.71 Subd. 2 -$500.00
1730 - Individualized Medication Management Plan - 144g.71 Subd. 5 - $500.00
1820 - Prescriptions - 144g.71 Subd. 13 - $500.00
1940 - Individualized Treatment Or Therapy Management - 144g.72 Subd. 3 - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 23, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $5,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

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

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	24264		R 07/23/2025

NAME OF PROVIDER OR SUPPLIER

GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE

1940 MAJOR DRIVE
GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments 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: SL24264016-1 On July 21, 2025, through July 23, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 25, 2025. At the time of the survey, there were five residents; all of them received services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include	{0 630}		

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{0 630}	Continued From page 3 the required content for two of two residents (R1, R2). 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: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's IAPP dated May 28, 2025, indicated R1 was not at risk to be abused by others. R1's IAPP did not indicate if R1 was at risk for abusing other vulnerable adults or any specific measures to be taken to minimize the risk of abuse to that person (if applicable). R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent	{0 630}		

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{0 630}	Continued From page 4 urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's IAPP dated July 18, 2025, indicated R2 was not at risk to be abused by others. R2's IAPP did not indicate if R2 was at risk for abusing other vulnerable adults or any specific measures to be taken to minimize the risk of abuse to that person (if applicable). On July 22, 2025, at 10:07 a.m., clinical nurse supervisor (CNS)-C stated they did not make correction to either resident's IAPP. CNS-C stated, "I missed it". No further information was provided.	{0 630}		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	{0 650}		

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{0 650}	Continued From page 5 (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 two of two employees (unlicensed personnel (ULP)-A, ULP-I). 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). The findings include: ULP-A ULP- A was hired on January 29, 2018, to provide direct cares and services to residents. On April 23, 2025, at 8:41 a.m., the surveyor observed ULP-A administer oral medications to R3.	{0 650}		

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{0 650}	Continued From page 6 ULP-A's employee record lacked the following: - annual performance review (last completed on July 6, 2023). ULP-I ULP- I was hired on January 29, 2018, to provide direct cares and services to residents. ULP-I's employee record lacked the following: - annual performance review (last completed on July 6, 2023). On July 21, 2025, at 11:22 a.m., ULP-A stated they had not received any recent performance evaluation. On July 21, 2025, at 2:45 p.m., licensed assisted living director (LALD)-D stated human resource (HR) and clinical nurse supervisor (CNS)-C were responsible for completing the annual performance review. On July 21, 2025, at 2:47 p.m., CNS-C stated they did not complete an annual performance review for either ULP; CNS-C stated they did not receive a request from HR that the ULPs needed an annual performance review completed. The licensee's Performance Review policy dated July 29, 2021, indicated each supervisor will complete the annual performance review form for each employee they supervise on or before the employee's anniversary date. The supervisor will meet with employees annually on or before their anniversary date to review the employee's feedback, review the supervisor's assessment of the employee's performance, and discuss goals for the upcoming period.	{0 650}		

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{0 650}	Continued From page 7 No further information was provided.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	{0 680}		

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{0 680}	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan entitled Fire Safety & Evacuation Plan dated March 17, 2025, lacked evidence of the following required content: - risk assessment for the facility; - quarterly review of missing resident plan; - strategies for addressing facility and community-based risks (evacuation plans, staffing, surges/shortages, back-up plans); - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for volunteers; - roles under a waiver declared by secretary; and - sharing information on occupancy and needs. On July 21, 2025, at 12:59 p.m., licensed assisted living director (LALD)-D provided the surveyor with an EPP dated March 17, 2025, that they brought from the main office. LALD-D stated the did not have the EPP onsite because it was still under revision. LALD-D stated revising the EPP required a lot of information, and it took time, "this is the best I could do".	{0 680}		

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{0 680}	Continued From page 9 The licensee's Emergency and Disaster Preparedness policy dated July 29, 2021, indicated the licensee's facilities will be prepared to manage emergency and disaster situations, including missing residents through the hazard assessment and emergency planning. The policy read, "1. A hazard vulnerability assessment (HVA) has been completed to identify the most probable emergency situations that may be experienced by this facility or community. 2. An assisted living facility with dementia care that has a secured dementia care unit must include in their hazard vulnerability assessment a safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 3. Based on the HVA, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. (e) The emergency disaster plan contains a plan	{0 680}		

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{0 680}	Continued From page 10 for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. 7. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. §483.73(c). 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R. §483.73(c). A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 9. The facility provides building emergency exit diagrams to all residents. 10. Emergency exit diagrams are posted on each floor. 11. Training and Exercises. (a) The facility provides training in emergency and disaster preparedness policies and procedures to all staff during the initial staff orientation and annually thereafter and makes emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (b) Training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles. (c) The facility conducts exercises to test the Emergency Preparedness Plan at least twice per year in compliance with 42 C.F.R. §483.73(d)(2). 12. The emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and	{0 680}		

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(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
{0 680}	Continued From page 11 updated at least annually." No other information was provided.	{0 680}		
{0 790} SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{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) staff 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	{0 810}		

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{0 810}	Continued From page 12 or unusual resident needs for movement or evacuation. (c) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01350} SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all	{01350}		

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{01350}	Continued From page 13 requirements for training and competency evaluation for one of one unlicensed personnel ((ULP/pool)-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP/Pool-L was contracted by the licensee from a supplemental nurse staffing agency (SNSA) to provide direct cares and services to residents. ULP/Pool-L started working for the licensee on May 12, 2025 (first shift picked up by ULP/Pool-L per human resource (HR)-E). The licensee's employee schedule dated June 29, 2025, through August 2, 2025, indicated ULP/Pool-L was scheduled to work the following shifts: Night shifts (11:00 p.m., to 7:00 a.m.,) on July 2, July 16, July 30, 2025; Morning shift (7:00 a.m., to 3:00 p.m.,) on July 26, 2025; and Evening shift (3:00 p.m., to 11:00 p.m.,) on July 26, 2025. R1's Medication Administration Summary- Month for the month of July 2025, indicated R1's medication administration was performed by ULP/Pool-L on July 2, and July 16, 2025, for 11:30 p.m., administration time. R1's Service Recap Summary -Month for the	{01350}		

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{01350}	Continued From page 14 month of July 2025, indicated ULP/Pool-L performed R1's overnight services. On July 23, 2025, at 10:09 a.m., ULP-A stated ULP/Pool-L did perform all of the residents' care and service. ULP-A stated, "[ULP/Pool-L] does the same thing I do, grooming, bathing, dressing, and everything". ULP/Pool-L's record included EduCare (online training platform) transcript dated March 9, 2025; training and competency for nail care assistance, bathing assistance, intake and output tracking, medication administration on all routes, blood glucose testing, catheter care, CPAP care, and hand washing. ULP/Pool-L's record included a certificate of completion in recognition of satisfactory completion of Minnesota Nurse Aide Training dated March 21, 2025. ULP/pool-L's employee records lacked evidence of completed training and competency evaluation to include the following topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) maintenance of a clean and safe environment; (4) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	{01350}		

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{01350}	Continued From page 15 (8) preparation of modified diets as ordered by a licensed health professional; (9) awareness of confidentiality and privacy; (10) procedures to use in handling various emergency situations; and (11) awareness of commonly used health technology equipment and assistive devices. In addition, ULP/pool-L's employee records lacked training and competency evaluation to include; (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; On July 23, 2025, at 11:56 a.m., via telephone, human resource manager (HR)-E stated ULP/Pool-L took the certified nursing assistance (CNA) test but the school did not submit the documents to the state of Minnesota for certification. On July 23, 2025, at 12:19 p.m., via telephone, HR-E stated ULP/Pool-L took the CNA test towards the end of March but ULP/Pool-L was not certified through the state of Minnesota for the reasons mentioned above. On July 23, 2025, at 12:21 p.m., via telephone, HR-E stated ULP/Pool-L started working at the	{01350}		

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{01350}	Continued From page 16 licensee's facility on May 12, 2025. On July 23, 2025, at 12:24 p.m., via telephone, HR-E stated they did review ULP/Pool-L's training record, but they were not aware ULP/Pool-L was missing some stuff. HR-E stated they trusted the SNSA staff, "I was not aware that I have to be watchful of the pool staffing". HR-E stated SNSA ULPs shadowed the licensee's ULPs for 16 hours before they started working on their own. HR-E stated they did not have documentation to show what SNSA's staff learned by shadowing the licensee's staff. The licensee's Delegation of Nursing Tasks policy dated July 29, 2021, indicated the registered nurse (RN) will establish a system to assure that individual contractors or temporary staff who will be performing delegated nursing tasks, treatments or assigned therapy tasks meet all the training requirements and are competent to perform the delegated tasks to meet the individual resident's needs and preferences. No further information was provided.	{01350}		
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b).	{01460}		

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{01460}	Continued From page 17 (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensure requirements and regulations before providing assisted living services to residents for one of three employees (unlicensed personnel (ULP)/pool-L). 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	{01460}		

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{01460}	Continued From page 18 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: ULP/Pool-L was contracted by the licensee from a supplemental nurse staffing agency (SNSA) to provide direct cares and services to residents. ULP/Pool-L started working for the licensee on May 12, 2025 (first shift picked up by ULP/Pool-L per human resource (HR)-E). The licensee's employee schedule dated June 29, 2025, through August 2, 2025, indicated ULP/Pool-L was scheduled to work the following shifts: Night shifts (11:00 p.m., to 7:00 a.m.,) on July 2, July 16, July 30, 2025; Morning shift (7:00 a.m., to 3:00 p.m.,) on July 26, 2025; and Evening shift (3:00 p.m., to 11:00 p.m.,) on July 26, 2025. R1's Medication Administration Summary- Month for the month of July 2025, indicated R1's medication administration was performed by ULP/Pool-L on July 2, and July 16, 2025, for 11:30 p.m., administration time. R1's Service Recap Summary -Month for the month of July 2025, indicated ULP/Pool-L performed R1's overnight services. On July 23, 2025, at 10:09 a.m., ULP-A stated ULP/Pool-L did perform all of the residents' care and service. ULP-A stated, "[ULP/Pool-L] does	{01460}		

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{01460}	Continued From page 19 the same thing I do, grooming, bathing, dressing, and everything". ULP/Pool-L's employee record lacked orientation to assisted living facility licensure requirements and regulations to include the following topics: (1) an overview of Assisted living statute (144G.08 to 144G.95); (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (5) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (6) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On July 23, 2025, at 12:21 p.m., via telephone, HR-E stated ULP/Pool-L started working at the licensee's facility on May 12, 2025. On July 23, 2025, at 12:24 p.m., via telephone, HR-E stated they did review ULP/Pool's training record, but they were not aware ULP/Pool-L was missing some stuff. HR-E stated they trusted the SNSA staff, "I was not aware that I have to be watchful of the pool staffing". HR-E stated SNSA	{01460}		

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{01460}	Continued From page 20 ULPs shadowed the licensee's ULPs for 16 hours before they started working on their own. HR-E stated they did not have documentation to show what SNSA's staff learned by shadowing the licensee's staff. The licensee's Assisted Living Orientation-All Staff policy dated July 29, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. a. If any volunteers provide services to assisted living residents, they will also receive orientation to assisted living facility and licensing requirements. b. Orientation to assisted living facility licensing requirements and regulations is only required upon hire and is provided by the licensee. c. Orientation to assisted living facility licensing requirements and regulations provided by a previous organization is not transferrable to this organization. No further information was provided.	{01460}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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,	{01620}		

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{01620}	Continued From page 21 whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for four of five residents (R1, R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated August 30, 2023, indicated R1 received services for medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's record included 90-day nursing assessments dated February 26, 2025, and May 28, 2025. The assessment completed on May 28, 2025, was 1 day past the 90-calendar day requirement.	{01620}		

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{01620}	Continued From page 23 R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received services for activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's record included 90-day nursing assessments dated March 12, 2025, and July 18, 2025. The assessment completed on July 18, 2025, was 38 days past the 90-calendar day requirement. R4 R4 was admitted to the licensee on August 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's signed service agreement dated May 2, 2025, indicated R4 received services for activity assistance, appointment reminders, meal assistance, behavior management, record weight, medication administration, laundry, safety checks, bathing, and grooming. R4's record included 90-day nursing assessments dated March 12, 2025, and July 21, 2025 (during this follow up survey). The assessment completed on July 21, 2025, was 41 days past the 90-calendar day requirement.	{01620}		

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{01620}	Continued From page 24 R5 R5 was admitted to the licensee on July 5, 2023. R5's diagnosis included hypertension, chronic kidney disease, heart failure, and hypotension. R5's service plan dated July 5, 2023, indicated R5 received assistance with bathing, dressing, grooming, ambulation, and medication administration. R5's record included 90-day nursing assessments dated March 12, 2025, and June 19, 2025. The assessment completed on June 19, 2025, was nine days past the 90-calendar day requirement. On July 22, 2025, at 9:29 a.m., clinical nurse supervisor (CNS)-C stated, they did not know why the assessments were completed late. CNS-C stated they had another survey at the licensee's sister facility and did not have time to complete they assessments on time. The licensee's Initial and On-going Nursing Assessment of Residents policy dated July 29, 2021, indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment; b. 14-day assessment: completed up to 14-days after start of services; c. Ongoing assessment: completed periodically but no less than every 90-days; and d. Change in resident condition; e. Preparing modified diets ordered by a licensed health professional. The RN will also complete assessments as	{01620}		

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NAME OF PROVIDER OR SUPPLIER: GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1940 MAJOR DRIVE, GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01620}	Continued From page 25 indicated by individual resident circumstances. A RN or LPN may complete the ongoing monitoring of a resident who receives only one or more of the following services: dressing, self-feeding, oral hygiene, hair care, grooming, toileting and bathing; standby assistance; verbal or visual reminders to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication, providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises. No further information was provided.	{01620}		
{01640} SS=D	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 26 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 the service plan was completed within 14 days of admission and included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of three residents (R4). In addition, the licensee also failed to ensure the resident's service plan accurately reflected their assessed needs. 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: R4 was admitted to the licensee on August 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's record included signed Service Plan (waiver)- Addendum to contract dated effective May 2, 2025. R4's record also included most recent 90-day nursing assessment dated July 21, 2025.	{01640}		

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{01640}	Continued From page 27 R4's service plan dated May 2, 2025, indicated R4 received assistance with the following services: - assistance with activity daily; - annual physician orders by RN yearly; - appointment reminders/ assistance one day a week; - assistance with bathing one day a week; - assistance with behavior management three times daily; - assistance with grooming two times daily; - assistance with laundry two days a week; - assistance with meal three times per day; - medication administration three times per day; - record weight monthly; and - safety checks nine times per day. R4's most recent 90-day nursing assessment completed on March 12, 2025, indicated the following activities of daily living (ADL) needs: - bathing needs - independent, no help required for bathing/showering; - dressing needs - independent, able to choose clothing and dress and undress self; - eating needs- feeding -independent, no help needed to eat; - hygiene / grooming/ oral- independent, does own grooming and hygiene, needs reminders for grooming and hygiene (teeth or dentures, shaving, hair; - mobility - independent; - toileting needs - independent; and - medication management- needs full management and set up. R4's service plan was not revised based on R4's assessment.	{01640}		

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{01640}	Continued From page 28 On July 22, 2025, at 8:43 a.m., unlicensed personnel (ULP)-A stated R4 was very independent; ULP-A stated they did not help R4 with dressing or grooming, and R4 took care of their own appointments. ULP-A stated they helped R4 with medication administration and meal preparation. ULP-A also stated R4 did not have behaviors, and they did not do behavior management for R4. On July 22, 2025, at 10:22 a.m., clinical nurse supervisor (CNS)-C stated R4 was very independent, and they might have forgotten to update the service plan. The licensee's Contents of Service Plan policy dated July 29, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. A proposed service plan is established after completion of individualized, initial assessment. A finalized service plan will be completed no later than 14 calendar days after initiation of services. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided.	{01640}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	{01700}		

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{01700}	Continued From page 29 providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for three of three residents (R2, R3, R5). 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	{01700}		

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{01700}	Continued From page 30 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: R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. On July 21, 2025, at 11:41 a.m., the surveyor observed the following medications in R2's room: - Therawork Relief for Muscle Cramps Foam (topical); - polyethylene glycol 3350 oral powder; and - docusate sodium 100mg soft gel capsules. R2's medication administration record (MAR) dated July 2025, included the following: - polyethylene glycol powder, give once a day as needed. R2's Individualized Medication Management Plan (IMMP) dated July 18, 2025, indicated medication self-administration was not applicable, R2 could only self-administer topical	{01700}		

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{01700}	Continued From page 31 medications for muscle cramps or a suppository, and R2 needed medication management and setup. The Medication Administration section of the IMMP read, "Independent-self-administer medications safely. Needs reminders to take medication" which contradicted the above self-administration medication entry. R2's Self Administration of Medication Assessment (SAM) dated June 8, 2025, read, "Med [medication] self-administration was not applicable, can only self-administer topical for muscle cramps and suppository". R2's IMMP and SAM did not indicate R2 was assessed and deemed competent to self-administer the following medications: - polyethylene glycol 3350 oral powder; and - docusate sodium 100mg soft gel capsules. R3 R3 was admitted to the licensee on January 15, 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed service plan dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. On July 21, 2025, at 11:43 a.m., the surveyor observed the following medications in R3's room: - fludrocortisone 0.15mg, ½ tab, contained one ½ tab. R3's IMMP completed on July 21, 2025, (during the survey) indicated medication self-administration was not applicable except for	{01700}		

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{01700}	Continued From page 32 inhalers and cromolyn sodium. R3's SAM dated July 1, 2025, indicated medication self-administration was not applicable, contradicting with R3's IMMP mentioned above. R3's IMMP and SAM did not indicate R3 was assessed and deemed competent to self-administer the fludrocortisone. On July 21, 2025, at 11:43 a.m., R3 stated they were self-administering the fludrocortisone. R5 R5 was admitted to the licensee on July 5, 2023. R5's diagnosis included hypertension, chronic kidney disease, heart failure, and hypotension. R5's service plan dated July 5, 2023, indicated R5 received assistance with bathing, dressing, grooming, ambulation, and medication administration. On July 21, 2025, at 11:53 a.m., the surveyor observed the following medications in R5's room: - Systane eye drop. R5's IMMP completed on June 19, 2025, indicated medication self-administration was not applicable; trained, unlicensed staff to assist with and administer medication as delegated. R5's IMMP and SAM did not indicate R5 was assessed and deemed competent to self-administer the eye drop. On July 21, 2025, at 11:48 a.m., R5 stated they did self-administer the eye drops three times a	{01700}		

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{01700}	Continued From page 33 day. On July 22, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-C stated R3 was only self-administering inhalers and cromolyn sodium. CNS-C stated R3 was taking fludrocortisone and stated R3 did not self-administer the fludrocortisone. When the surveyor asked why R3 had fludrocortisone in their room, CNS-C stated it was an empty bottle. When the surveyor replied the bottle was not empty, CNS-C stated R3 just picked up the medication from pharmacy. Surveyor explained to CNS-C the surveyor had observed there was one ½ tablet in the bottle. CNS-C went into R3's room obtained the fludrocortisone bottle and confirmed that there was ½ tab of fludrocortisone in the bottle. CNS-C then stated they gave R3 the bottle so R3 could reorder the medication, and stated they did not know there was a half tablet left in the bottle. On July 22, 2025, at 10:35 a.m., CNS-C stated R2 could only self-administer the Therawork and suppository. CNS-C stated they did not know where the polyethylene glycol powder came from; R2 did not take polyethylene glycol powder or docusate. CNS-C further stated the unlicensed personnel (ULP) should be watching out for medications in resident rooms. The surveyor referred CNS-C to the pharmacy label on both of the above-mentioned medications and asked if CNS-C knew where the medication came from. CNS-C stated it was Veterans Affairs (VA) pharmacy. CNS-C stated they were aware that R2 gets medication from the VA pharmacy. On July 22, 2025, at 10:44 a.m., CNS-C stated the licensee's staff did all of R5's medication administration. CNS-C stated R5 had their own	{01700}		

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{01700}	Continued From page 34 eye drops but there was no SAM completed for the eye drops. CNS-C did not know why the assessment was not completed. On July 23, 2025, at 10:00 a.m., ULP-A stated they were aware the above-mentioned residents had medications in their room. ULP-A stated CNS-C was also aware because R3 had different providers and R3 ordered their own medication. ULP-A stated R2 also ordered their own medications because R2 received some of their medications from the VA (Veterans Affairs). On July 23, 2025, at 10:14 a.m., CNS-C stated in assisted living, they could not stop residents from ordering their own medications. CNS-C stated R2 ordered their own medication from the VA. When the surveyor inquired if the licensee had system in place to monitor what medication were delivered to the residents' room, CNS-C stated they told the ULPs to not deliver medication to residents' rooms other than ointment. CNS-C further stated the ULPs were supposed to leave the medication upstairs in the medication room or bring it down to the nurses' office. The licensee's Storage of Medications policy indicated a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the resident that will address storage of the resident's medications.	{01700}		

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{01700}	Continued From page 35 No further information was provided.	{01700}		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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 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	{01730}		

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{01730}	Continued From page 36 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 interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of two residents (R2). 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 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: R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms.	{01730}		

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{01730}	Continued From page 37 R2's Service Plan (Waiver)- Addendum to Contract dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's record included Individualized Medication Management Plan (IMMP) dated July 18, 2025. R2's IMMP lacked the following: - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; - 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; and - current medication management record updated when there are any changes. On July 23, 2025, at 9:22 a.m., clinical nurse supervisor (CNS)-C stated they had not had a chance to correct R2's IMMP due to heavy	{01730}		

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{01730}	Continued From page 38 workload. The licensee's Documentation of Medication Management, Treatment and Therapy Management Services dated July 29, 2021, indicated the registered nurse will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment plan and resident's medication/treatment record (MAR/TAR). No further information was provided.	{01730}		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current medication orders for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 was admitted to the licensee on January 15,	{01820}		

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(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
{01820}	Continued From page 39 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed service plan dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. R3's electronic medication administration record (eMAR) for the month of July 2025, indicated R3 received the following medications: - Levodopa 50 milligrams (mg); - Carbidopa levodopa 12.5mg; - cromolyn sodium ½ vial; - Diazepam 2mg; - Eszopiclone 2mg; - fludrocortisone 0.1mg; - loratadine 10mg; - magnesium 500mg; - Midodrine 10mg; - MiraLAX 17gram (g); - mirtazapine 7.5mg; - sodium chloride 1g; - Carbidopa 5mg; - Levodopa 50mg; - Carbidopa levodopa 25-250, 12.5mg; - Carbidopa levodopa 50-200; - Buspirone 15mg; - Donepezil 5mg; - Zyflo 600mg; - Carbidopa 5mg; - clozapine 100mg; - clozapine 25mg; - hydroxyzine (no dose); - Levalbuterol inhaler puffs; - levodopa 25-250mg; - Lidocaine; and - methocarbamol 500mg.	{01820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	24264		R 07/23/2025

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{01820}	Continued From page 40 R3's record lacked signed physician's orders for medications. On July 22, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-C stated they called the in-house provider yesterday, July 21, 2025, (during the survey) and the provider sent a signed order. CNS-C stated R3 had multiple providers and each provider had their own orders. On July 22, 2025, at 9:17 a.m., CNS-C provided the surveyor with R3's signed physician order, (a Microsoft word document) entitled Medications-Current-By Time dated July 21, 2025, via email correspondence. No further information was provided.	{01820}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks	{01940}		

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{01940}	Continued From page 41 that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R1) who received blood glucose monitoring. 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 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes.	{01940}		

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{01940}	Continued From page 42 R1's signed service agreement dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's prescriber order signed October 18, 2022, indicated fingerstick glucose monitoring twice daily before breakfast and evening meal. R1's Individualized Treatment and Therapy Plan as of July 21, 2025, was blank and did not indicate R1's blood glucose monitoring plan. R1's Service Recap Summary - Month for the month of July 2025, indicated Accucheck blood sugar check. R1's record lacked specific instruction related to blood glucose monitoring. R1's record lacked procedures for notifying a registered nurse or appropriate health professional when a problem arises with blood glucose monitoring. On July 23, 2025, at 10:00 a.m., unlicensed personnel (ULP)-A stated they did not have specific instructions for performing blood glucose checks for R1 and when to call the nurse related to blood sugar monitoring. On July 23, 2025, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated there was no clear instruction for the ULPs regarding R1 blood sugar monitoring. CNS-C stated it got missed when R1 was admitted. The surveyor reminded CNS-C that the licensee was cited for the same reason on previous survey and inquired about their intervention after receiving the orders.	{01940}		

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{01940}	Continued From page 43 CNS-C stated they had not made corrections and stated they were supposed to call the providers. No further information was provided.	{01940}		

Electronically Delivered

June 6, 2025

Licensee
Golden Valley Residence
1940 Major Drive
Golden Valley, MN 55422

RE: Project Number(s) SL24264016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 25, 2025, 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.

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $12,500.00**. 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

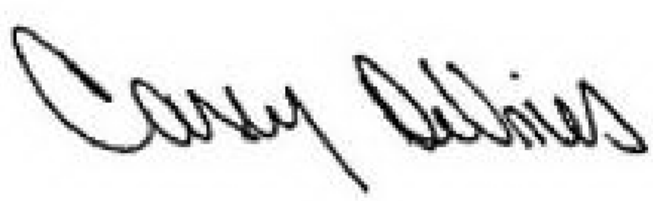
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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 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
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	24264		04/25/2025

NAME OF PROVIDER OR SUPPLIER

GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE

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0 000	Initial Comments 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: SL24264016-0 On April 21, 2025, through April 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; all of them received services under the Assisted Living Facility license. An immediate correction order was identified on April 22, 2025, issued for SL24264016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on April 22, 2025, issued for SL24264016-0, tag identification 1290.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 000	Continued From page 1 During the survey, the licensee took action to mitigate the immediate risk for tag identification 1290. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on April 22, 2025, issued for SL24264016-0, tag identification 2310. An immediate correction order was identified on April 24, 2025, issued for SL24264016-0, tag identification 1750. During the survey, the licensee took action to mitigate the immediate risk for tag identification 1750. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must:	0 340		

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0 340	Continued From page 2 (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0480, 0680) for a survey completed on April 5, 2023. This had the potential to affect all residents, staff, and visitors at the facility. 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 April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated the licensee was familiar with current minimum assisted living requirements. On April 25, 2025, at 9:40 a.m., licensed assisted living director (LALD)-D stated they did not have plan of correction to document the actions taken by the facility to comply with the correction orders. The licensee lacked documentation to indicate	0 340		

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0 340	Continued From page 3 correction orders previously cited on April 5, 2023, were in full compliance with assisted living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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 observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year to determine staffing levels to meet the needs of all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of six residents and had census of five residents during the survey. On April 21, 2025, at approximately 12:00 p.m., during the entrance conference, CNS-C stated the owners of the facility did the staffing plan. CNS-C further stated the owners assigned one unlicensed personnel (ULP) for five or less residents and two ULPs for six or more residents. On April 25, 2025, at 9:25 a.m., licensed assisted living director (LALD)-D stated the owners were responsible for the staffing plan. LALD-D stated the staffing plan needed to be reviewed every	0 470		

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0 470	Continued From page 5 year and as needed. LALD-D further stated the CNS, and the owners reviewed the staffing plan. On April 25, 2025, at 10:25 a.m., CNS-C stated they were not aware of the requirement to have a staffing plan previously until a recent survey conducted at the licensee's sister facility. CNS-C stated they did not have a written staffing plan. The licensee's Staffing, Direct-Care Staffing Plan and Daily Scheduling policy dated July 29, 2021, indicated the clinical nurse supervisor, or designee would develop, write, and implement a staffing plan that would provide direct-care staffing sufficient to meet the residents needs 24-hours a day, seven-days a week. The policy also indicated the staffing plan will be evaluated for appropriateness of staffing levels in the facility and revised as needed and twice a year at a minimum. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	0 480		

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0 480	Continued From page 6 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be	0 480		

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	24264		04/25/2025

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0 480	Continued From page 7 provided with a self-closing door. 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 April 22, 2025, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 8 The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Ombudsman for Long Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 21, 2025, at 12:45 p.m., during the facility tour, the surveyor observed contact information for the Minnesota Adult Abuse Reporting Center (MAARC), posted on a bulletin board by the main entrance. The surveyor	0 550		

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0 550	Continued From page 9 observed the licensee lacked the following postings: - OOLTC; - OMHDD; and - OHFC. On April 25, 2025, at 9:13 a.m., licensed assisted living director (LALD)-D stated they were aware of the requirement to post the above listed contact information. LALD-D stated they just started working for the licensee and did not get the chance to review postings as they were responsible for overseeing five facilities. The licensee's Complaint Policy and Procedure dated July 29, 2021, read, "1. Each resident or resident representative receives written notice of our facility's process for receiving and resolving complaints. At admission, the designated representative will receive a copy of the complaint policy and process. The complaint policy will be posted in the entrance area. 2. The written notice includes: a. The resident's right to complain to our facility about the services received from our staff; b. The method of submitting a complaint to our facility; and c. A description of the facility's complaint resolution process available to residents d. The name and contact information of the person representing the facility designated to handle and resolve complaints. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. f. A statement that our facility will not take any action that negatively affects a resident in retaliation for a complaint made or a concern	0 550		

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0 550	Continued From page 10 expressed by the resident or the resident's representative. 3. Complaints may be submitted orally or in writing. 4. Complaint follow-up process: a. All oral and written complaints will be directed to the LALD. b. The LALD will review the complaint and determine the most appropriate staff person to investigate and follow-up and assign the complaint to that staff person. c. The staff person will complete the complaint investigation and follow-up and document appropriately on the complaint form. d. The completed complaint form will be routed to the LALD for final review. 5. The person lodging the complaint will receive notification of the follow-up, as appropriate, by the LALD or designee within 5 business days. Complaints are reviewed during the facility's quality management process. 6. There will be no retaliation against a resident or employee if a complaint / grievance is filed in good faith on behalf of the resident. 7. Complaints and resolution will be kept in the resident's record while resident is active at the residence" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the	0 580		

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0 580	Continued From page 11 quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 24, 2025, at 2:37 p.m., clinical nurse supervisor (CNS)-C stated the licensee did not have quality management activities. CNS-C stated they had a meeting held with the owners recently, but it was not documented. On April 25, 2025, at 9:56 a.m., licensed assisted living director (LALD)-D stated there had not been quality management activities in the past, but they	0 580		

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0 580	Continued From page 12 would incorporate quality management activities going forward. The licensee's Quality Improvement plan policy, dated July 29, 2021, indicated the Assisted Living Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality services for residents. All staff will be involved in the implementation of performance improvement efforts. The Quality Council meetings will be held at least quarterly to evaluate the quality of care. Quality Council meeting minutes will be retained for two-years and will be made available to the commissioner at the time of survey, investigation, or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, R2). 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: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's IAPP dated February 26, 2025, indicated R1 was not at risk to be abused by others. R1's IAPP did not indicate if R1 was at risk for abusing other vulnerable adults or any specific measures to be taken to minimize the risk of abuse to that person (if applicable).	0 630		

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0 630	Continued From page 14 R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's IAPP dated March 12, 2025, indicated R2 was not at risk to be abused by others. R2's IAPP did not indicate if R2 was at risk for abusing other vulnerable adults or any specific measures to be taken to minimize the risk of abuse to that person (if applicable). On April 23, 2025, at 9:58 a.m., clinical nurse supervisor (CNS)-C stated they were aware the IAPP was not detailed enough, but they did not know what was missing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 15 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 two of two employees (unlicensed personnel (ULP)-A, ULP-I). 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). The findings include: ULP-A ULP- A was hired on January 29, 2018, to provide	0 650		

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0 650	Continued From page 16 direct cares and services to residents. On April 23, 2025, at 8:41 a.m., the surveyor observed ULP-A administer oral medications to R3. ULP-A's employee record lacked the following: - annual performance review (last completed on July 6, 2023). ULP-I ULP- I was hired on January 29, 2018, to provide direct cares and services to residents. ULP-I's employee record lacked the following: - annual performance review (last completed on July 6, 2023). On April 25, 2025, at 10:18 a.m., human resource manager (HR)-E stated they could not find any annual performance reviews completed in year 2024 for the above-mentioned employees. HR-E stated clinical nurse supervisor (CNS)-C was responsible for completing the annual performance review. On April 25, 2025, at 10:20 a.m., CNS-C stated they were not working for the licensee when the performance evaluation was due for ULP-A and ULP-I (July 6, 2024) and stated they did not complete any performance evaluations after they got hired on July 29, 2024. The licensee's Performance Review policy dated July 29, 2021, indicated each supervisor will complete the annual performance review form for each employee they supervise on or before the employee's anniversary date. The supervisor will meet with employees annually on or before their anniversary date to review the employee's	0 650		

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0 650	Continued From page 17 feedback, review the supervisor's assessment of the employee's performance, and discuss goals for the upcoming period. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 18 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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: The licensee's emergency disaster preparedness plan entitled Fire Safety & Evacuation Plan dated March 17, 2025, lacked evidence of the following required content: - establishment of the emergency program; - develop and maintain the emergency preparedness plan; - risk assessment for the facility; - quarterly review of missing resident plan; - strategies for addressing facility and community-based risks (evacuation plans, staffing, surges/shortages, back-up plans); - emergency plan (EP) patient population; - process for EP collaboration with local, tribal, regional and State and Federal; - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers;	0 680		

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0 680	Continued From page 19 - arrangement with other facilities; - roles under a waiver declared by secretary; - emergency official contact information; - primary and alternative means for communication; - methods for sharing information; - sharing information on occupancy and needs; - long-term care (LTC) family notifications, and; - emergency preparation and testing requirements. On April 21, 2025, at 12:51 p.m., the surveyor requested to see the licensee's EPP. Licensed assisted living director (LALD)-D stated an engineering evaluator, who surveyed the licensee's sister facility, said the EPP utilized for multiple locations was outdated; LALD-D stated they started working for the licensee on March 17, 2025, and they were updating the EPP for all of the licensee's facilities. On April 21, 2025, at 12:53 p.m., the surveyor inquired about what they would use as a reference in case of emergency/disaster. Unlicensed personnel (ULP)-A stated they did have a book in the nurse's office, but it was no longer there, and they did not know where it went. On April 21, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-C stated the EPP plan they had was from 2014 and had not been updated since. On April 24, 2025, at approximately 2:45 p.m., CNS-C provided the surveyor with the Fire Safety & Evacuation Plan dated March 17, 2025, and stated that was what they had for an EPP. On April 25, 2025, at 9:22 a.m., LALD-D stated they were aware the EPP was missing required contents, and they were working on fixing the	0 680		

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0 680	Continued From page 20 EPP and other documents. The licensee's Emergency and Disaster Preparedness policy dated July 29, 2021, indicated the licensee's facilities will be prepared to manage emergency and disaster situations, including missing residents through the hazard assessment and emergency planning. The policy read, "1. A hazard vulnerability assessment (HVA) has been completed to identify the most probable emergency situations that may be experienced by this facility or community. 2. An assisted living facility with dementia care that has a secured dementia care unit must include in their hazard vulnerability assessment a safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 3. Based on the HVA, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.	0 680		

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	24264		04/25/2025

NAME OF PROVIDER OR SUPPLIER
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0 680	Continued From page 21 (e) The emergency disaster plan contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. 7. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. §483.73(c). 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R. §483.73(c). A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 9. The facility provides building emergency exit diagrams to all residents. 10. Emergency exit diagrams are posted on each floor. 11. Training and Exercises. (a) The facility provides training in emergency and disaster preparedness policies and procedures to all staff during the initial staff orientation and annually thereafter and makes emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (b) Training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles. (c) The facility conducts exercises to test the Emergency Preparedness Plan at least twice per year in compliance with 42 C.F.R. §483.73(d)(2). 12. The emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and	0 680		

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0 680	Continued From page 22 updated at least annually." No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff, and visitors. 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 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 April 22, 2025, from 10:15 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and	0 775		

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0 775	Continued From page 23 maintenance (MX)-F. During the tour, the surveyor asked MX-F to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: One window measuring 17 inches clear width, 52 inches clear height, and 884 square inches total open area. Bedroom 6: One window measuring 17 inches clear width, 40 inches clear height, and 680 square inches total open area. Bedroom 7: One window measuring 17 inches clear width, 40 inches clear height, and 680 square inches total open area. UNOCCUPIED SLEEPING ROOMS: Bedroom 3: One window measuring 17 inches clear width, 52 inches clear height, and 884 square inches total open area. The windows in bedrooms 3, 4, 6, and 7 did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On April 22, 2025, the surveyor explained to LALD-D and MX-F that an immediate correction order was issued for the above findings. LALD-D and MX-F stated they understood the	0 775		

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0 775	Continued From page 24 requirements for egress windows and would start the process of getting the windows modified or replaced. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 790		

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0 790	Continued From page 25 On April 22, 2025, from 10:15 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and maintenance (MX)-F. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. On April 22, 2025, MX-F stated they did not know monthly visual inspections were required. No further information was 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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 26 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EVACUATION DIAGRAMS On April 22, 2025, from 10:15 a.m. to 11:30 a.m., the surveyor observed the doors of each resident	0 810		

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0 810	Continued From page 27 sleeping room were not identified with numbers as indicated on the posted evacuation floor plan map. The resident sleeping room doors are required to be identified with a number matching the number on the posted evacuation floor plan map, in order to provide direction to the building occupants and emergency responders in the event of a fire or similar emergency. On April 22, 2025, 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. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety & Evacuation Plan, dated March 17, 2025, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 28 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On April 22, 2025, at 12:30 p.m., LALD-D stated they would work on developing their FSEP to be specific to their facility and residents. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-D lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On April 22, 2025, at 12:30 p.m., LALD-D stated they had no documentation on resident or staff training. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-D lacked documentation showing any	0 810		

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0 810	Continued From page 29 evacuation drills were completed at the facility. On April 22, 2025, at 12:30 p.m., LALD-D stated they had no documentation on evacuation drills, but had an evacuation drill planned for the month of May. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900		

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0 900	Continued From page 30 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 was admitted to the licensee on September 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's unsigned service agreement dated May 22, 2025 [sic], indicated R4 received services for assisting with medication administration, laundry, safety checks, bathing, and grooming. R4's record lacked a written contract with licensee's facility address, which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided	0 900		

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0 900	Continued From page 31 directly by the licensee or by management agreement or other agreement; and - the resident's service plan. In addition, R4's records lacked evidence a contract had been executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the licensee must offer the resident the opportunity to identify a designated representative. On April 22, 2025, at 4:33 p.m., clinical nurse supervisor (CNS)-C stated R4 had no assisted living contract and no signed service plan. CNS-C stated they just started working for the licensee when R4 was admitted therefore the contract and the service plan was not done. CNS-C was hired on July 29, 2024. On April 23, 2025, at 9:56 a.m., CNS-C stated the marketing person who was supposed to do the contract was on a leave of absence and although the LPN who was also responsible to do the contract did not do it. CNS-C stated the licensed assisted living (LALD) was responsible for keeping track of the records, but it was not done. On April 25, 2025, at 10:05 a.m., licensed assisted living director (LALD)-D stated they did not know R4 was missing a signed assisted living contract from their record. LALD-D started working for the licensee on March 17, 2025.	0 900		

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0 900	Continued From page 32 The Licensee's Resident's Record policy dated July 29, 2021, read, "1. Record entries will be legible, permanently recorded, dated, and signed by the person making the entry. 2. The Licensed Assisted Living Director and the CNS will determine where records are kept depending upon whether or not a resident is receiving clinical services. 3. The resident record will contain: a. Identifying information about the resident and the resident's family or designated representative including: i. Resident name; ii. Address; iii. Telephone Number; iv. Date of Birth; v. Dates of the beginning and end of services; vi. Names, addresses, and telephone numbers of an emergency contact, family members identified by the resident and/or resident's designated representative; b. Names, addresses and telephone numbers of the resident's health and medical service providers and other assisted living providers, if known; c. Health information, if applicable to services received, including i. Medical history ii. Primary diagnosis and any other relevant current diagnoses; iii. Allergies, if any; iv. Orders or prescriptions for medications, treatments or therapies that the agency will be managing; and v. Individualized medication management plan, if applicable vi. Individualized treatment and/or therapy management plan(s), if applicable vii. Other relevant health records.	0 900		

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0 900	Continued From page 33 d. The resident's advance directive, if any; e. Health care directives; guardianships, powers of attorney, or conservatorships; f. Our assisted living agency's previous and current assessments and service plans; g. Individualized abuse prevention plan h. All records of communications pertinent to the resident's assisted living services. i. Documentation that services have been provided as identified in the service plan. j. Documentation of significant changes in the resident's status and actions taken in response to these changes and the resident's needs, including reporting to the appropriate supervisor or health care personnel; k. Documentation of incidents involving the resident and actions taken in response to the needs of the resident, including pertinent details of the incident and, reporting to the appropriate supervisor or healthcare professional; l. Documentation that the resident has received and reviewed the following: i. The assisted living bill of rights and documentation that the agency staff has reviewed the bill of rights with the resident; ii. A description of the process by which residents may file a complaint or concern about assisted living services, including an explicit statement that the agency and staff will not discriminate or retaliate against a resident for expressing concerns or complaints. m. Documentation of complaints received from the resident, the resident's family and/or the resident's representative and the investigation and resolution of those complaints. n. Discharge summary, including service termination notice and related documentation when applicable; o. Other documents relevant to the resident's services or status.	0 900		

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0 900	Continued From page 34 4. Legal Record. The resident record is a legal document. Information will not be removed or destroyed during the required period of time that the resident record must be retained. Original entries will not be covered or deleted. 5. Resident records will be retained for at least five years after the resident's discharge or termination of services or as otherwise required by state regulations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study	01290		

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	24264		04/25/2025

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GOLDEN VALLEY RESIDENCE

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01290	Continued From page 35 (BGS) was submitted and received in affiliation with the assisted living license's health facility identification number (HFID) for three of seventeen employees (unlicensed personnel/pool (ULP/pool)-B, unlicensed personnel (ULP)-H, activities assistant (A)- G). 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). The findings include: ULP/Pool-B ULP/Pool-B was a contracted staff from a supplemental nurse staffing agency (SNSA) by the licensee to provide direct cares and services to residents. On April 22, 2025, at 9:30 a.m., human resource manager (HR)-E stated they (the licensee) do not run BGS for pool staff and stated they would get the BGS for ULP/Pool-B from the SNSA. On April 22, 2025, at 10:35 a.m., via email, HR-E provided the surveyor with ULP/Pool-B's employee record which contained a BGS clearance letter completed by another assisted living facility not affiliated to the licensee or the SNSA. On April 22, 2025, at 11:00 a.m., HR-E stated that they found out from the SNSA that the SNSA runs	01290		

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01290	Continued From page 36 national BGS' only and the licensee was responsible for running the Department of Human Services NETStudy BGS. HR-E stated they were not aware that they were responsible for running the BGS until today. On April 22, 2025, at 11:12 a.m., ULP-A stated ULP/Pool-B did not pass medication to residents but ULP/Pool-B helps with other resident cares. ULP-A stated ULP/Pool-B did answered call lights and helped residents unsupervised. On April 22, 2025, at 11:13 a.m., ULP/Pool-B stated they assist residents with all cares other than medications, unsupervised. On April 22, 2025, at approximately 11:55 a.m., ULP/Pool-B stated the had worked for the licensee on the following dates from 9:00 a.m., to 12:00 p.m.: - February 1, 2025; - March 15, 2025; - March 18, 2025; and - April 22, 2025. ULP- H ULP- H was hired on February 24, 2025, to provide direct care and services to residents. ULP-H's employee record included BGS clearance letter dated February 13, 2024, and indicated ULP-H was affiliated to the licensee's sister facility under HFID # 31856. The licensee's employee schedule for the month of April 2025, indicated ULP-H was scheduled to work on April 1, 2025, PM shift, from 3:00 p.m., to 11:00 p.m. A-G	01290		

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01290	Continued From page 37 A-G was hired on February 28, 2025, as an activity assistant to help residents with activities. A-G's employee record included BGS clearance letter dated March 15, 2025, and indicated A-G was affiliated to the licensee's sister facility under HFID# 32015. On April 22, 2025, at 12:43 p.m., via email, HR-E indicated A-G worked for the licensee Monday through Friday from 9:00 a.m., to 2:00 p.m., or 3:00 p.m., depending on the activity calendar events. On April 22, 2025, at 9:28 a.m., via telephone, HR-E stated they forgot to affiliate ULP-H and A-G to the licensee's HFID. The licensee's NetStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services) Employee Roster dated April 21, 2025, indicated ULP-H and A-G's BGS was affiliated to the licensee's HFID# 24264 on April 21, 2025, during the survey. The licensee's Background Checks policy dated July 29, 2021, indicated all employees as well as contractors, and regularly scheduled volunteers of the facility with resident direct contact will undergo a background study through department of human services (DHS). Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01350	Continued From page 38	01350		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation for one of one unlicensed personnel ((ULP/pool)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP/Pool-B was contracted by the licensee from a supplemental nurse staffing agency (SNSA) to provide direct cares and services to residents. ULP/Pool-B started working for the licensee on February 1, 2025. On April 22, 2025, at 11:12 a.m., ULP-A stated ULP/Pool-B did not pass medication to residents, however ULP/Pool-B helped with other resident cares. ULP-A stated ULP/Pool-B answered call lights and helped residents unsupervised. On April 22, 2025, at 11:13 a.m., ULP/Pool-B	01350		

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01350	Continued From page 39 stated they helped residents unsupervised with all cares other than medication administration. On April 22, 2025, at approximately 11:55 a.m., ULP/Pool-B stated they had worked for the licensee on the following dates from 9:00 a.m., to 12:00 p.m. - February 1, 2025; - March 15, 2025; - March 18, 2025; and - April 22, 2025. ULP/pool-B's employee records lacked evidence of completed training and competency evaluation to include the following topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for	01350		

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01350	Continued From page 40 the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. In addition, ULP/pool-B's employee records lacked training and competency evaluation to include; (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; (7) administering medications or treatments as required; and other RN/professionally delegated tasks (e.g., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts, etc.). On April 22, 2025, at 10:41 a.m., via telephone, human resource manager (HR)-E stated they did not have any training records they could access from the SNSA's employee record file for ULP/Pool-B. On April 22, 2025, at 10:41 a.m., via telephone, HR-E stated they did not realize that they had to do all the training for ULP/pool-B, and their	01350		

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01350	Continued From page 41 expectation was that the SNSA completed all the required training for pool staff. HR-E stated they just found out from the SNSA that the licensee was responsible for training the employees contracted through the SNSA. The licensee's Delegation of Nursing Tasks policy dated July 29, 2021, indicated the registered nurse (RN) will establish a system to assure that individual contractors or temporary staff who will be performing delegated nursing tasks, treatments or assigned therapy tasks meet all the training requirements and are competent to perform the delegated tasks to meet the individual resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01350		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the	01460		

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01460	Continued From page 42 same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensure requirements and regulations before providing assisted living services to residents for one of three employees (unlicensed personnel (ULP)/pool-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01460		

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01460	Continued From page 43 The findings include: ULP/Pool-B was contracted by the licensee from a supplemental nurse staffing agency (SNSA) to provide direct cares and services to residents. ULP/Pool-B started working for the licensee on February 1, 2025. On April 22, 2025, at 11:12 a.m., ULP-A stated ULP/Pool-B did not pass medication to residents, however ULP/Pool-B helped with other resident cares. ULP-A stated ULP/Pool-B answered call lights and helped residents unsupervised. On April 22, 2025, at 11:13 a.m., ULP/Pool-B stated they helped residents unsupervised with all cares other than medication administration. On April 22, 2025, at approximately 11:55 a.m., ULP/Pool-B stated they had worked for the licensee on the following dates from 9:00 a.m., to 12:00 p.m. - February 1, 2025; - March 15, 2025; - March 18, 2025; and - April 22, 2025. ULP/Pool-B's employee record lacked orientation to assisted living facility licensure requirements and regulations to include the following topics: (1) an overview of this chapter (144G.08 to 144G.95); (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01460		

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01460	Continued From page 44 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On April 22, 2025, at 10:41 a.m., via telephone, human resource manager (HR)-E stated they did not have any training records they could access from the SNSA's employee record file for ULP/Pool-B. On April 22, 2025, at 10:41 a.m., via telephone, HR-E stated they did not realize that they had to do all the training for ULP/pool-B, and their expectation was that the SNSA completed all the required training for pool staff. HR-E stated they just found out from the SNSA that the licensee was responsible for training the employees contracted through the SNSA. The licensee's Assisted Living Orientation-All Staff policy dated July 29, 2021, indicated all	01460		

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01460	Continued From page 45 assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. a. If any volunteers provide services to assisted living residents, they will also receive orientation to assisted living facility and licensing requirements. b. Orientation to assisted living facility licensing requirements and regulations is only required upon hire and is provided by the licensee. c. Orientation to assisted living facility licensing requirements and regulations provided by a previous organization is not transferrable to this organization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470		

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01470	Continued From page 46 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 47	01470		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (unlicensed personnel (ULP)-H).

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:

ULP-H was hired on February 23, 2024, as a housekeeper.

The licensee's employee schedule for the month of April 2025, indicated ULP-H was scheduled to work as caregiver to provide direct care and services to residents on April 1, 2025, from 3:00 p.m., to 11:00 p.m.

ULP-H's employee record included an Educare (training software) transcript dated February 28, 2024, through May 7, 2025. The transcript indicated ULP-H completed assisted living bill of rights training.

ULP-H's employee records lacked evidence of

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(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
01470	Continued From page 48 orientation to assisted living regulations for the following topics: - an overview of this chapter (144G.08 to 144G.95); - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On April 24, 2025, at 11:49 a.m., via telephone, human resource manager (HR)-E stated ULP-H was hired as housekeeper and later transitioned into a caregiver role. HR-E stated they were responsible for assigning trainings to both new hires and current employees. HR-E also stated it was their responsibility to make sure all employees had completed their required training	01470		

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	24264		04/25/2025

NAME OF PROVIDER OR SUPPLIER: GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1940 MAJOR DRIVE, GOLDEN VALLEY, MN 55422

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01470	Continued From page 49 before they were assigned to work independently with residents. HR-E stated ULP-H was an exception as ULP-H transitioned from a housekeeping role to caregiver role. HR-E further stated ULP-H had worked with a formerly employed licensed practical nurse (LPN) but there was no documentation to show that ULP-H was trained or deemed competent on medication administration or other delegated tasks. HR-E further stated the nurse who worked with ULP-H reported that ULP-H was capable of doing the job. On April 24, 2025, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated ULP-H primarily worked at the licensee's sister facilities. CNS-C stated ULP-H did everything that other ULPs do for the residents. On April 24, 2025, at 12:41 p.m., via telephone, HR-E stated they did not know the exact date when ULP-H started working as a caregiver. HR-E further stated ULP-H was still listed as a housekeeper in Homebase (human resource software utilized by the licensee). On April 24, 2025, at 1:49 p.m., during a phone interview, ULP-H stated they were first hired as a housekeeper and then started working as a caregiver. ULP-H did not remember when they transitioned to a caregiver role. ULP-H stated they were trained on how to cook, clean, assist residents with showers, toileting, and medication administration by a nurse who was no longer employed by the licensee and by other coworkers. On April 24, 2025, at 2:30 p.m., CNS-C stated they were hired after ULP-H, and they had no awareness of ULP-H's lack of training or	01470		

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01470	Continued From page 50 demonstration of competency. The licensee's Assisted Living Orientation-All Staff policy dated July 29, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. a. If any volunteers provide services to assisted living residents, they will also receive orientation to assisted living facility and licensing requirements. b. Orientation to assisted living facility licensing requirements and regulations is only required upon hire and is provided by the licensee. c. Orientation to assisted living facility licensing requirements and regulations provided by a previous organization is not transferrable to this organization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics	01530		

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01530	Continued From page 51 specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-H) received at least eight hours of initial dementia care training within 160 working hours of their employment start date. 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: ULP-H was hired on February 23, 2024, as a housekeeper. The licensee's employee schedule for the month	01530		

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01530	Continued From page 52 of April 2025, indicated ULP-H was scheduled to work as a caregiver to provide direct care and services to the licensee's residents on April 1, 2025, from 3:00 p.m., to 11:00 p.m. ULP-H's employee record included an Educare (online training platform) transcript which indicated ULP-H had 0.50 hours of dementia training completed on March 21, 2024, 1.00 hours of dementia training completed on March 27, 2024, and 1.75 hours of dementia training completed on May 7, 2024, for a total of 3.25 hours of dementia training since hire, which was 4.75 hours short of the required eight hours of dementia training. On April 24, 2025, at 11:49 a.m., via telephone, human resource manager (HR)-E stated ULP-H was hired as housekeeper and later transitioned into a caregiver role. HR-E stated they were responsible for assigning trainings to both new hires and current employees. HR-E also stated it was their responsibility to make sure all employees had completed their required training before they were assigned to work independently with residents. HR-E stated ULP-H was an exception as ULP-H transitioned from a housekeeping role to caregiver role. HR-E further stated ULP-H had worked with a formerly employed licensed practical nurse (LPN) but there was no documentation to show that ULP-H was trained or deemed competent on medication administration or other delegated tasks. HR-E further stated the nurse who worked with ULP-H reported that ULP-H was capable of doing the job. On April 24,2025, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated ULP-H primarily worked at the licensee's sister facilities. CNS-C	01530		

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01530	Continued From page 53 stated ULP-H did everything that other ULPs do for the residents. On April 24, 2025, at 12:41 p.m., via telephone, HR-E stated they did not know the exact date when ULP-H started working as a caregiver. HR-E further stated ULP-H was still listed as a housekeeper in Homebase (human resource software utilized by the licensee). On April 24, 2025, at 1:49 p.m., during a phone interview, ULP-H stated they were first hired as a housekeeper and then started working as a caregiver. ULP-H did not remember when they transitioned to a caregiver role. ULP-H stated they were trained on how to cook, clean, assist residents with showers, toileting, and medication administration by a nurse who was no longer employed by the licensee and by other coworkers. The licensee's Assisted Living Dementia Training indicated staff will receive required training on dementia care during orientation and annually. Employees of a licensed assisted living or a licensed assisted living with dementia care who have not completed their initial dementia care training will not provide direct care independently: i. There will be another employee onsite while this employee is working who 1. completed the initial eight hours of training on topics related to dementia care 2. will serve as a resource for the employee who has not completed all of the initial dementia care training ii. A trainer or supervisor will be available for consultation with the new employee until the training requirement is complete. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start	01530		

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01530	Continued From page 54 date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, for one of three residents (R4).	01610		

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01610	Continued From page 55 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: R4 was admitted to the licensee on August 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's unsigned service agreement dated May 22, 2025[sic], indicated R4 received services for medication administration, laundry, safety checks, bathing, and grooming. R4's record included an assessment history, which indicated an admission assessment was completed on August 23, 2024, 14-day nursing assessment on September 14, 2024, another 14-day nursing assessment on September 20, 2024, and 90-day nursing assessments on, November 25, 2024, and March 12, 2025. The admission assessment completed on August 23, 2024, was late by four days. On April 23, 2025, at 10:05 a.m., clinical nurse supervisor (CNS)-C stated, "I am the only RN dealing with all the houses, that is why it is late." The licensee's Initial and On-going Nursing Assessment of Residents policy dated July 29, 2021, indicated the RN will complete the following	01610		

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01610	Continued From page 56 comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment; b. 14-day assessment: completed up to 14-days after start of services; c. Ongoing assessment: completed periodically but no less than every 90-days; and d. Change in resident condition. The RN will also complete assessments as indicated by individual resident circumstances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 57 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of three residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated August 30, 2023, indicated R1 received services for medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's record included 90-day nursing	01620		

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01620	Continued From page 58 assessments dated August 10, 2024, November 27, 2024, and February 26, 2025. The assessment completed on November 27, 2024, was 19 days past the 90-calendar day requirement. The assessment completed on February 26, 2025, was 1 day past the 90-calendar day requirement. R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received services for activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's record included 90-day nursing assessments dated August 10, 2024, November 27, 2024, and March 12, 2025. The assessment completed on November 27, 2024, was 19 days past the 90-calendar day requirement. The assessment completed on March 12, 2025, was 15 days past the 90-calendar day requirement. R4 R4 was admitted to the licensee on August 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's unsigned service agreement dated May 22, 2025[sic], indicated R4 received services for medication administration, laundry, safety checks, bathing, and grooming.	01620		

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01620	Continued From page 59 R4's record included an assessment history, which indicated an admission assessment was completed on August 23, 2024, 14-day nursing assessment completed on September 14, 2024, another 14-day nursing assessment completed on September 20, 2024, and 90-day nursing assessments completed on, November 25, 2024, and March 12, 2025. The 14-day assessment completed on September 14, 2024, was eight days past the 14-calendar day requirement. The assessment completed on November 25, 2024, was 19 days past the 90-calendar day requirement. The assessment completed on March 12, 2025, was 15 days past the 90-calendar day requirement. On April 23, 2025, at 10:05 a.m., clinical nurse supervisor (CNS)-C stated, "I am the only RN dealing with all the houses that is why it is late." CNS-C stated the licensed practical nurses (LPN) were supposed to do the 90-day assessments under the supervision of the RN, but it was not done. CNS-C further explained what they mean by LPNs could do 90-day assessments under supervision of the RN and stated "I mean she can ask questions, and I also go through whatever assessment she has done to make sure nothing was missed. But she has not done it." CNS-C stated the LPN had not completed any assessment for any of the residents at the licensee's facility. The licensee's Initial and On-going Nursing Assessment of Residents policy dated July 29, 2021, indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment; b. 14-day assessment: completed up to 14-days	01620		

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01620	Continued From page 60 after start of services; c. Ongoing assessment: completed periodically but no less than every 90-days; and d. Change in resident condition; e. Preparing modified diets ordered by a licensed health professional. The RN will also complete assessments as indicated by individual resident circumstances. A RN or LPN may complete the ongoing monitoring of a resident who receives only one or more of the following services: dressing, self-feeding, oral hygiene, hair care, grooming, toileting and bathing; standby assistance; verbal or visual reminders to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication, providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	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	01640		

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01640	Continued From page 61 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 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 the service plan was completed within 14 days of admission and included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of three residents (R4). In addition, the licensee also failed to ensure the resident's service plan accurately reflected their assessed needs. 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: R4 was admitted to the licensee on August 19, 2024. R4's diagnoses included Parkinson's	01640		

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NAME OF PROVIDER OR SUPPLIER: GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1940 MAJOR DRIVE, GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 62 disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's record included unsigned Service Plan (private)- Addendum to contract dated effective April 9, 2025, and unsigned Service Plan (waiver)- Addendum to Contract dated effective May 22, 2025 (SIC). R4's record also included most recent 90-day nursing assessment dated March 12, 2025. R4's unsigned current service agreement dated April 9, 2025, indicated R4 received assistance with the following services: - assistance with activity daily; - annual physician orders by RN yearly; - assistance with bathing one day a week; - assistance with behavior management three times daily; - assistance with grooming two times daily; - assistance with laundry two days a week; - assistance with meal three times per day; - medication administration three times per day; - record weight monthly; and - safety checks nine times per day. R4's most recent 90-day nursing assessment completed on March 12, 2025, indicated the following activities of daily living (ADL) needs: - bathing needs - independent, no help required for bathing/showering; - dressing needs - independent, able to choose clothing and dress and undress self; - eating needs- feeding -independent, no help needed to eat; - hygiene / grooming/ oral- independent, does own grooming and hygiene, needs reminders for grooming and hygiene (teeth or dentures, shaving, hair;	01640		

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01640	Continued From page 63 - mobility - independent; - toileting needs - independent; and - medication management- needs full management and set up. R4's service plan was not revised based on R4's assessment. R4's service plan, due to be completed by September 2, 2024, was completed on April 9, 2025, which was 219 days past the 14 calendar days requirement. Also, the service plan was not signed or authenticated by the resident or resident's designated representative. On April 22, 2025, at 4:33 p.m., clinical nurse supervisor (CNS)-C stated R4 had no assisted living contract and no signed service plan. CNS-C stated they just started working for the licensee when R4 was admitted to the licensee therefore the contract and the service plan was not done. CNS-C was hired on July 29, 2024. On April 23, 2025, at 9:56 a.m., CNS-C stated they completed the admission assessment, and the licensed practical nurse (LPN) a former employee of the licensee was supposed to print the service plan and get it signed. The marketing person who was supposed to do the contract was on a leave of absence and although the LPN who was also responsible to do the contract did not do it. CNS-C stated the licensed assisted living (LALD) was responsible for keeping track of the records, but it was not done. The licensee's Contents of Service Plan policy dated July 29, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. A proposed service plan is established after completion of individualized, initial assessment. A finalized service plan will be	01640		

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01640	Continued From page 64 completed no later than 14 calendar days after initiation of services. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700		

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01700	Continued From page 65 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed Service Plan (Waiver)- Addendum to Contract dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks.	01700		

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01700	Continued From page 66 On April 21, 2025, at 12:59 p.m., the surveyor observed the following medications placed on R1's bedside table in R1's room: - calcium carbonate antacid tablets100mg; - acetaminophen 500mgs; - refresh eye drops; - vitamin A&D ointment; and - triple antibiotic ointment. R1's medication administration record (MAR) dated April 2025, included the following: - acetaminophen (Tylenol) 1000 milligrams(mg) daily as needed (PRN) every six hours; - A&D ointment (Daily) apply to peri area as needed for incontinence; and - Artificial Tears Ophthalmic solution (Daily) apply 1-2 drops to both eyes as needed up to 4x a day. R1's individualized medication management plan (IMMP) dated February 26, 2025, indicated R1 could only self-administer vitamin A&D ointment, eye drops, and Tums. R1's undated Self Administration of Medication Assessment (SAM) printed on April 21, 2025, indicated medication self-administration was not applicable and R1 could only self-administer vitamin A&D ointment, eye drops, and Tums. R1's IMMP and SAM did not indicate assessment of the resident's self-administration capabilities for acetaminophen. R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms.	01700		

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01700	Continued From page 67 R2's Service Plan (Waiver)- Addendum to Contract dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. On April 21, 2025, at 1:02 p.m., the surveyor observed the following medications in R2's room: - Therawork muscle cramp foam; - Bisacodyl 10mg; - ProstaGenix (two bottles); - Polyethylene glycol 3350 oral powder; - Swiss kriss herbal laxative; and - Prostate Saw palmetto and beta sitosterol R2's MAR dated April 2025, included the following: - Polyethylene glycol powder give PRN once a day as needed. R2's IMMP dated March 12, 2025, indicated medication self-administration was not applicable, R2 could only self-administer topical medication for muscle cramps, suppository (Bisacodyl), and R2 needed medication management and setup. However, the Medication Administration section of the IMMP read, "Independent-self-administer medications safely. Needs reminders to take medication", which contradicted with the above self-administration medication entry. R2's undated SAM printed on April 21, 2025, indicated medication self-administration was not applicable. R2's IMMP and SAM did not indicate assessment of the resident's self-administration capabilities of any medication.	01700		

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01700	Continued From page 68 On April 21, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated R2 could self-administer Vitamin A&D and R2 could self-administer the Therawork muscle cramp foam and the Bisacodyl suppository. R3 R3 was admitted to the licensee on January 15, 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed Service Plan (Waiver)- Addendum to Contract dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. On April 24, 2025, at 2:45 p.m., the surveyor observed CNS-C bring a Xopenex inhaler from R3's room and stated R3 kept it in their room for self-administration. R3's MAR dated April 2025, included the following: - Levalbuterol HFA INH (200PF) (Daily) Inhale 2 puffs into the lungs every 4 hours as needed for shortness of breath or wheezing. (Starts: 4/16) R3's 90-day nursing assessment completed on February 26, 2025, indicated medication self-administration was not applicable for R3, and the licensee was to administer all medication to resident. On April 23, 2025, at 12:41 p.m., CNS-C stated for self-medication assessment they would assess if residents were able to open and close the medication bottle, state the name of the medication dosage, time, and what they were	01700		

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01700	Continued From page 69 taking the medication for. CNS-C also stated they would assess if residents were able to determine when to take PRN medication. CNS-C further stated they were not aware of the medications the surveyor found in residents' room except the vitamin A & D found in R1's room, and they did not do the assessment for the above-mentioned residents, "no, I did not do it, just put medication self-administration was not done." On April 23, 2025, at 12:51 p.m., CNS-C stated a SAM was not completed for R3's inhaler when R3 got admitted to the licensee. CNS-C stated they did not know R3 had Xopenex inhalers until they got the medication from the pharmacy a couple weeks ago. On April 24, 2025, at 3:49 P.m., CNS-C stated they were responsible for monitoring medication supplies. CNS-C stated they knew R3 had an order for inhaler, but they thought R3 did not have any supply of the inhaler. CNS-C stated the SAM was not done upon R3's admission and they did not work for the licensee when R3 got admitted. CNS-C stated they did not complete the SAM after they became aware of R3's possession of the inhaler. CNS-C stated they had a state survey back-to-back and did not have the time to finish doing what they were supposed to be doing. The licensee's Storage of Medications policy indicated a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the	01700		

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01700	Continued From page 70 RN will develop an individualized medication management plan for the resident that will address storage of the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 reassessment when there was a change in the resident's condition for one of three residents (R2). 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:	01710		

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01710	Continued From page 71 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan (Waiver)- Addendum to Contract dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's Prescriber Authorization of Non-Controlled Medication Orders dated January 8, 2025, included provider orders for the following: - acetaminophen 1000 milligrams (mg) every 12 hours as needed (PRN); - atorvastatin calcium 40mg, 1 tablet (tab) daily; - Azelaic acid 15% Gel, apply thin layer to face daily; - baclofen 20 mg, four times daily (8:00 a.m., 2:00 p.m., 8:00 p.m., 2:30 a.m.); - chlorhexidine Gluconate 0.12 % mouthwash swish and spit 10mls daily; - diclofenac sodium 1% gel apply 4 gram daily to side pain three times daily PRN; - fleet mineral oil enema rectally daily as needed; - glydo latex-free 2% apply to affected areas topically with catheter changes; - lactulose 10mg/15ml solution, 30ml orally daily as needed; - metronidazole 0.75% gel apply to affected areas thin layer on face every morning; - polyethylene glycol 3350 30 ounce-daily doses 17gram 1 does powder daily PRN; - Senna 8.6 mg tab, 1 tab daily; - Senna 8.6 mg tab, 1 tab daily PRN if no	01710		

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01710	Continued From page 72 bowel movement in 24 hours; and - Vitamin D3 25mcg tab 0.5 tab every Monday, Wednesday, and Friday. R2's electronic medication administration record (EMAR) dated April 1, 2025, through April 20, 2025, indicated R2 received the following medications: - baclofen 20mg give one tab four times a day (8:00 a.m., 2:00 p.m., 8:00 p.m., 2:30 a.m.); - metronidazole daily **self-administers; - finasteride 5mg take one daily; - Senna 8.6 give one tab daily; - Vitamin D3 12.5 mcg (Monday, Wednesday, Friday); - Vitron-C 200-125mg give one tab daily; - atorvastatin 40mg give one tablet daily; - acetaminophen five 2 tabs 1000mg daily; - baclofen give one 10mg tablet one time a day must be at least 3 hours before the schedule baclofen or 3 hours after schedule baclofen; - diclofenac, give diclofenac cream topically three times daily PRN; - dulcolax give 2-4 chews daily PRN for constipation; - dulcolax give 2-4 chews daily PRN (double entry); - hydrocodone give one tablet PRN for pain; - lactulose give one time a day PRN; - lidocaine apply topically PRN with catheter changes; - Mineral oil give mineral oil enema one time a day; - polyethene glycol powder give PRN once a day; and - Senna give PRN if no bowel movement in 24 hours. R2's Individualized Medication Management Plan (IMMP) dated March 12, 2025, indicated	01710		

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01710	Continued From page 73 medication self-administration was not applicable, R2 could only self-administer topical medication for muscle cramps, suppository (Bisacodyl), and R2 needed medication management and setup. However, the Medication Administration section of the IMMP read, "Independent-self-administer medications safely. Needs reminders to take medication", which contradicted with the above self-administration medication entry. R2's undated Self Administration of Medication Assessment (SAM) printed on April 21, 2025, indicated medication self-administration was not applicable. On April 22, 2025, at 4:39 p.m., unlicensed personnel (ULP)-A stated R2 had ordered "a bunch" of baclofen (muscle relaxants) from the pharmacy and clinical nurse supervisor (CNS)-C was aware. On April 23, 2025, at 1:08 p.m., CNS-C stated on January 6, 2025, ULPs reported to them that R2 was unable to get out of bed. CNS-C stated they came to the facility to assess R2 after the incident. CNS-C stated they asked R2 if they had been taking too much baclofen. The surveyor inquired how CNS-C suspected R2 was taking too much baclofen. CNS-C stated they asked R2 if R2 had lied to the pharmacy saying that they were going up north. The surveyor inquired about how CNS-C knew resident had called pharmacy. CNS-C stated, "I overheard him talk on the phone with pharmacy prior to the incident." CNS-C stated they did not do any intervention to stop the medication order after they overheard R2 ordering the baclofen on the phone. CNS-C stated on the day of the incident they found 10 tablets of baclofen at R2's bed side and the next day (on January 7, 2025) the ULPs found 60	01710		

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01710	Continued From page 74 more tablets. CNS-C further stated that they asked R2 if R2 had been taking baclofen and R2 answered yes. CNS-C stated they did not recall which ULP found the baclofen in R2's room or where in R2's room was the baclofen found. CNS-C also explained they were responsible for ordering R2's medications, but R2 had also been ordering their own medications in the past. CNS-C stated when R2 was unable to get out of bed, CNS-C called the provider. CNS-C further stated R2's nurse practitioner (NP) thought R2 was unable to get out of bed due to R2's diagnosis of multiple sclerosis (MS). CNS-C stated they then informed the NP that R2 had been self-medicating on baclofen in addition to the scheduled baclofen R2 was taking four times a day and that might have contributed to R2's change in condition of not being able to get out bed. CNS-C stated their intervention for the incident was to print out times of baclofen administration and post it in R2's room to give R2 reassurance that R2 was taking baclofen on time. CNS-C stated the date of the incident was January 6, 2025, and stated they wrote a progress note about the incident, but they did not write incident report. R2's progress note written by CNS-C dated January 6, 2025, contradicted the above interview with CNS-C and read, "Resident requested for PRN Baclofen 20 mg [milligram] incase he's away from the GH [group home]. Resident requested for contacts for Omnicare on Friday 01/03- writer offered the requested information. Resident reached out to the pharmacy, and they delivered 80 tabs of Baclofen 20 mg. Today the resident confirmed he's in possession of the medication." On April 23, 2025, at 1:45 p.m., CNS-C confirmed that they gave the pharmacy phone number to R2	01710		

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(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
01710	Continued From page 75 and that they were aware R2 had the baclofen in their room. CNS-C stated the pharmacy delivered the baclofen to the licensee's facility and a ULP gave it to R2, CNS-C did not recall which ULP delivered the medication to R2. On April 23, 2025, at 1:52 p.m., ULP-A stated R2 called the pharmacy and told them R2 was going out town and got the baclofen. "He kept it [baclofen] in his room, and he was taking it until he could not get out of bed. I cannot remember how much but a lot was gone in a week." R2's progress note from the primary care provider dated January 15, 2025, read, "Significant medication non-adherence issue identified. Nursing staff discovered patient had secretly obtained extra baclofen from pharmacy, in addition to scheduled doses. One bottle of baclofen was recovered from patient's room. Investigation revealed patient had been self-administering extra doses. Fortunately, no signs of overdose were noted during assessment. Addressed concern with patient, emphasizing importance of nurse - administered medications only. Patient agreed to adhere to prescribed regimen going forward, acknowledging potential health risks associated with self-medication". On April 23, 2025, at 2:28 p.m., CNS-C stated the provider found out about R2's change of condition from ULP-A on January 15, 2025. CNS-C stated ULP-A had also reported about residents' condition to them the whole week leading up to the 15th of January 2025. CNS-C stated they did not call the provider to report R2's change of condition because they knew the provider was coming to the facility on the 15th of January 2025. On April 23, 2025, at 2:50 p.m., ULP-A stated	01710		

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01710	Continued From page 76 they do write progress notes for resident's changes in condition; ULP-A stated they did not remember if they wrote a progress note about R2 not being able to get out of bed. On April 23, 2025, at 3:09 p.m., ULP-A stated the provider usually talked to them before visiting with the residents; they told the provider that R2 ordered and took a lot of baclofen, and he could not get out of bed. ULP-A stated CNS-C did not ask them to report to the provider, "No I just told him, he usually comes and talk to us." ULP-A stated R2 did not get out of bed for about a week. ULP-A stated they did report the situation to CNS-C. ULP-A stated CNS-C found and took some of the baclofen from R2's room. On April 23, 2025, at 3:10 p.m., ULP-I stated R2 was unable to get out of bed after taking the baclofen. ULP-I stated they did not deliver the baclofen to R2. ULP-I also stated the nurse took the remaining baclofen from R2. On April 23, 2025, at 3:20 p.m., CNS-C stated R2 had not done medication self-administration or ordering medication from pharmacy before this incident, which contradicted CNS-C's earlier statement to the surveyor on April 23, 2025, at 1:08 p.m. CNS-C then stated they reported the above-mentioned baclofen incident to the provider through ULP-A since they were not on site on the 15th of January 2025, when R2's provider visited R2. On April 23, 2025, at 3:28 p.m., the surveyor inquired if R2's provider knew about R2's change of condition that R2 was unable to get out bed since the providers note mentioned above indicated resident secretly took extra baclofen and no side effect. CNS-C stated yes, the	01710		

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01710	Continued From page 77 provider knew about the incident. CNS-C stated they reported R2 was defecating in the trash can as R2 was unable to get out bed to the provider and the provider wrote an order for a commode. R2's record included provider order dated January 16, 2025, which read, "-Please nurses to administer medications only. No self-administration of medications". On April 23, 2025, at 3:32 p.m., CNS-C stated they faxed the above order to the pharmacy. CNS-C stated they did not do change of condition assessment, and did not update individual medication management or medication self-administration assessment following R2's self-administration of baclofen incident. On April 23, 2025, at 3:48 p.m., the surveyor inquired to CNS-C if they did not do an incident report or change of condition assessment what investigation was the provider was referring to in their note "investigation revealed patient had been administering extra doses". CNS-C stated, "the investigation is the whole process that I have been telling you". Surveyor inquired how did the provider found out about the investigation since there was no documentation. CNS-C stated, "I told the aide [ULP-A], and the aide told [the provider]." The licensee's Storage of Medication policy dated July 29, 2021, read, "1. A registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or	01710		

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01710	Continued From page 78 other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the resident that will address storage of the resident's medications. 2. Proper Storage of Medications a. The RN will recommend where medications should be stored understanding that our agency may not be able to control where and how a resident stores his/her medications in their room. The RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. c. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer. d. A sample of medication provided to the resident by an authorized prescriber must be kept in its original container bearing the original label with legible directions for use. e. In the resident's individualized medication management plan, the RN may identify the need for secured storage of the medications within the resident's private living space because of the resident's cognitive status, concerns about medication diversion or other concerns, When	01710		

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01710	Continued From page 79 secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. f. The RN will also identify in the resident's individualized medication management plan a process for monitoring or tracking a resident's controlled or other medications that might be at risk of diversion. 3. The RN will develop a procedure to secure medications when they are delivered to the building. All medications will be given directly to the nurse or, nurse is not present, staff will lock up in staff mediation cabinets. No medications will ever be delivered directly to the resident in the resident's room for individuals receiving medication management. 4. The RN will establish a system that addresses the storage and handling of medications, including: a. How medications will be received and secured when delivered by the pharmacy b. Where medications will be stored c. How medications will be secured if in the resident's private living space or if centrally stored d. Who is authorized to access the medications? e. How refills and prescription renewals will be monitored. f. Controls and procedures to identify or prevent diversion of medications." No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 80 (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 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	01730		

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01730	Continued From page 81 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of three residents (R1, R2). 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 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: R1 R1 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed Service Plan (Waiver)- Addendum to Contract dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. The service agreement contained the following required information under the Individual Treatment and Therapy Management Plan (IMMP): - a statement describing the medication management service that will be provided;	01730		

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01730	Continued From page 82 - documentation of specific resident instructions relating to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel. R1's IMMP dated February 26, 2025, lacked the following information: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. R2 R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan (Waiver)- Addendum to Contract dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry.	01730		

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01730	Continued From page 83 The service plan contained the following required information under the IMMP: - a statement describing the medication management service that will be provided; - documentation of specific resident instructions relating to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel. R2's IMMP dated March 12, 2025, lacked: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; - 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; and - current medication management record updated when there are any changes. On April 23, 2025, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated they had not included all the required contents of the medication management plan. CNS-C stated they were looking through the resident files and they did not get to the medication management plans yet. The licensee's Documentation of Medication	01730		

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01730	Continued From page 84 Management, Treatment and Therapy Management Services dated July 29, 2021, indicated the registered nurse will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment plan and resident's medication/treatment record (MAR/TAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and evaluate the ULPs' ability to competently perform the task for one of three employees (ULP-H).	01750		

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01750	Continued From page 85 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 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: ULP-H was hired on February 23, 2024, as a housekeeper. The licensee's employee schedule for the month of April 2025, indicated ULP-H was scheduled to work as a caregiver to provide direct care and services to the licensee's residents on April 1, 2025, PM shift, from 3:00 p.m., to 11:00 p.m. ULP-H's employee record included an Educare (training software) transcript dated February 28, 2024, through May 7, 2025. The transcript did not indicate ULP-H completed medication administration training. ULP-H's employee record lacked evidence of training or competency in administering medication and other delegated tasks. R3's Medication Administration Summary- Month for the month of April 2025, indicated ULP-H administered the following medications on April 1, 2025, to R3 during the afternoon shift: - Levodopa 50 milligrams (mg) at 2:30 p.m.; - Carbidopa levodopa 12.5 mg at 4:30 p.m.; - Diazepam 2mg at 4:30 p.m.; - Midodrine 10mg at 4:30 p.m.; - Carbidopa 5mg at 4:30 p.m.;	01750		

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01750	Continued From page 86 - Levodopa 50mg at 4:30 p.m.; - Carbidopa levodopa 25-250 12.5 mg at 6:30 p.m.; - Carbidopa levodopa 50-200 ½ tablet at 6:30 p.m.; - Carbidopa 5mg at 6:30 p.m. - Buspirone 15mg at 8:30 p.m.; - Carbidopa levodopa 25-250 12.5 mg at 8:30 p.m.; - Carbidopa 5mg at 8:30 p.m.; - Donepezil 5mg at 8:30 p.m.; - Zyflo 600mg at 8:30 p.m.; - Carbidopa levodopa 25-250 12.5 mg at 10:30 p.m.; - Eszopiclone 2mg at 10:30 p.m.; - Carbidopa 5mg at 10:30 p.m.; - Clozapine 100mg at 10:30 p.m.; and - Levodopa 50mg at 10:30 p.m. On April 24, 2025, at 11:49 a.m., human resource manager (HR)-E stated ULP-H was hired as housekeeper and later transitioned into a caregiver role. HR-E stated they were responsible for assigning trainings to both new hires and current employees. HR-E also stated it was their responsibility to make sure all employees had completed their required training before they were assigned to work independently with residents. HR-E stated ULP-H was an exception as ULP-H transitioned from a housekeeping role to caregiver role. HR-E further stated ULP-H had worked with a formerly employed licensed practical nurse (LPN) but there was no documentation to show that ULP-H was trained or deemed competent on medication administration or other delegated tasks. HR-E further stated the nurse who worked with ULP-H reported that ULP-H was capable of doing the job. On April 24,2025, at 12:28 p.m., clinical nurse	01750		

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01750	Continued From page 87 supervisor (CNS)-C stated ULP-H primarily worked at the licensee's sister facilities. CNS-C stated ULP-H did everything that other ULPs do for the residents. On April 24, 2025, at 12:41 p.m., HR-E stated they did not know the exact date when ULP-H started working as a caregiver. HR-E further stated ULP-H was still listed as a housekeeper in Homebase (human resource software utilized by the licensee). On April 24, 2025, at 1:49 p.m., during a phone interview, ULP-H stated they were first hired as a housekeeper and then started working as a caregiver. ULP-H did not remember when they transitioned to a caregiver role. ULP-H stated they were trained on how to cook, clean, assist residents with showers, toileting, and medication administration by a nurse who was no longer employed by the licensee and other coworkers. On April 24, 2025, at 2:30 p.m., CNS-C stated they were hired after ULP-H, and they had no awareness of ULP-H's lack of training or demonstration of competency. The licensee's undated Supervision of Unlicensed Personnel policy read "1. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or Assigned Therapy Services. a. Direct Supervision of Staff Providing Delegated Tasks. Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. The RN will directly supervise staff	01750		

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01750	Continued From page 88 performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies the initial period of direct supervision, the RN and/or licensed health professional will determine the frequency of ongoing, additional direct supervision based on the individual staff person's performance and on the needs and condition of individual residents, the types of services being provided and the experience of the staff. i. Supervision is designed 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. ii. The RN or appropriate licensed health professional must directly supervise staff performing medication or treatment administration. The direct supervision must include observation of the staff administering the medication or treatment and the interaction with the resident. Supervision of All Staff on All Shifts or random scheduled visits. The RN and appropriate licensed health professional will periodically provide direct supervision of staff on all shifts or random scheduled visits based on the experience and performance of the staff, the needs and conditions of the residents, and the complexity of the services being performed. The RN and appropriate licensed health professional will also consider feedback, concerns or complaints from residents and residents' representatives and information gained in resident assessments to determine if any staff needs additional direct supervision and/or training. The RN or licensed health professional will develop a system to track direct supervision of staff to ensure that all staff is directly supervised during the year and that supervision occurs on all shifts.	01750		

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NAME OF PROVIDER OR SUPPLIER: GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1940 MAJOR DRIVE, GOLDEN VALLEY, MN 55422

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01750	Continued From page 89 2. Supervision of Unlicensed Staff Performing Services that are not Delegated by an RN or Licensed Health Professional. The RN or LALD will identify who will supervise unlicensed persons that provide services that are not delegated by an RN or a licensed health professional, such as housekeeping and laundry or other tasks defined as supportive services. These persons will be directly supervised within 30 days of beginning work and thereafter based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
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 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 ensure medication was administered as prescribed for one of one resident (R2).	01760		

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01760	Continued From page 90 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received assistance with: activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. R2's signed Prescriber Authorization of Non-Controlled Medication Orders dated January 8, 2025, included provider orders for baclofen 20 mg, four times daily (8:00 a.m., 2:00 p.m., 8:00 p.m., 2:30 a.m.). R2's electronic medication administration record (EMAR) dated January 1, 2025, through January 31, 2025, indicated R2 received baclofen 10mg one tab three times a day (8:00 a.m., 2:30 p.m., 2:30 a.m.) from January 24 through January 29, 2025; in addition to baclofen 20mg four times a day (8:00 a.m., 2:00 p.m., 8:00 p.m., 2:30 a.m.). R2's EMAR dated April 1, 2025, through April 30,	01760		

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01760	Continued From page 91 2025, also indicated R2 had an order for baclofen 10mg tablet by mouth 1 time a day as needed. Must be at least three hours before a scheduled dose or three hours after a scheduled baclofen. On April 24, 2025, at 8:46 a.m., via telephone, pharmacist (P)-J from licensee's preferred pharmacy stated a 20-day supply of baclofen 20mg was billed to R2 per R2's requests and the medication was sent out on January 4, 2025. P-J stated R2 only had a scheduled baclofen order and R2 did not have a PRN order for baclofen. On April 24, 2025, at 10:37 p.m., clinical nurse supervisor (CNS)-C stated R2 had an order for baclofen 10mg one time a day PRN. The surveyor inquired to see the order for the PRN baclofen. On April 24, 2025, at 12:57 p.m., via telephone, P-K from license's preferred pharmacy stated R2 did not have an order for PRN baclofen, or a 10mg baclofen order. R2 only had a 20 mg of baclofen order. On April 24, 2025, at 4:05 p.m., CNS-C stated they got the baclofen 10mg give one tab three times a day (8:00 a.m., 2:30 p.m., 2:30 a.m.) order from R2's primary care physician notes and entered it into the EMAR. CNS-C stated they called pharmacy and learned that R2 only had a baclofen order for 10mg then they discontinued the baclofen 10mg order on January 29, 2025. CNS-C explained since they did not have a baclofen 10 mg tablet, they had been splitting the 20mg to make it 10mg and that was what the ULPs had been administering to R2. On April 25, 2025, at 11:00 a.m., CNS-C stated they did not have current order for baclofen 10mg	01760		

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01760	Continued From page 92 or PRN, they got the order from a provider's note and that was old. R2's record included a document from R2's primary care provider titled Evaluation and Management dated December 11, 2024, and mentioned above by the CNS as the "provider's note" on page five under Assessment and Plan indicated to continue baclofen 20mg at 8:00 a.m., 20mg at 8:00 p.m., and 20mg at 2:30 a.m. The document also included a historical dosage (previous order) for baclofen 10mg three times a day, 20mg at bedtime, and 10mg at bedtime as needed not to be given within three hours of scheduled dose. CNS-C stated they mistakenly thought the historical dose was the current order and entered it into the EMAR. CNS-C confirmed R2 had received extra doses of baclofen 10mg for about six days from January 24 through January 29, 2025. CNS-C stated the procedure for medication errors was to complete a medication error form, call providers, family/case manager, and retrain the employee if needed. CNS-C stated they did not follow any of the above listed procedure for medication error for R2, CNS-C stated, "I did not report because I am the one who did the medication error." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	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.	01770		

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01770	Continued From page 93 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of a medication setup for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted to the licensee on January 15, 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed service plan dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. On April 23, 2025, at 8:30 a.m., the surveyor observed R3's medication administration performed by ULP-A. ULP-A opened the medication cabinet located in the kitchen and took a pill box containing nine unknown pills, pre-set by the registered nurse (RN) for ULPs to administer. ULP-A opened the Wednesday AM (morning) slot and dumped nine pills into a cup, then ULP-A cross checked the pill with the electronic medication administration record to	01770		

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01770	Continued From page 94 match the nine pills they dumped into a cup and then administered the pills to R3. R3's record included medication setup documentation form entitled Medication Setup/ Review Summary-Month, from April 1, 2025, to April 30, 2025. The form contained name of medication, quantity of dose, times to be administered, route of administration, and initials of various ULPs on the date of administration from April 1, 2025, to April 23, 2025. On April 25, 2025, at 10:53 a.m., clinical nurse supervisor (CNS)-C stated they did setup medication for R3 every week in a pill box to last for seven days. CNS-C stated the medication setup documentation was completed by ULPs when the ULPs administered medications to R3. CNS-C stated they were unable to complete the medication setup documentation as they had to rush to go deal with the state survey for the licensee's other location. CNS-C stated they usually wrote progress notes for medication set up documentation, however CNS-C was unable to provide the progress notes. R3's record lacked 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 which was supposed to be done at the time of setup and by the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01820	Continued From page 95	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current medication orders for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 was admitted to the licensee on January 15, 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed service plan dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. R3's record included unsigned after visit summary dated January 10, 2025. R3's electronic medication administration record (eMAR) for the month of April 2025, indicated R3	01820		

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01820	Continued From page 96 received the following medications: - Levodopa 50 milligrams (mg); - Carbidopa levodopa 12.5 mg; - Diazepam 2mg; - Eszopiclone 2mg; - fludrocortisone 0.1mg; - loratadine 10mg; - magnesium 500mg; - Midodrine 10mg; - mirilax 17gram (g); - mirtazapine 7.5mg; - sodium chloride 1g; - Carbidopa 5mg; - Levodopa 50mg; - Carbidopa levodopa 25-250 12.5 mg; - Buspirone 15mg; - Donepezil 5mg; - Zyflo 600mg; - Carbidopa 5mg; - clozapine 100mg; and - clozapine 25mg. R3's records lacked signed physician's orders for medications. On April 24, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated R3 kept their own record for medication orders. CNS-C stated they used the after-visit summary (AVS) they got from R3 as a physician order. CNS-C stated R3 did not use the licensee's preferred pharmacy and in house physician. CNS-C further stated they received phone calls from different providers regarding R3's medication orders, then R3 would print the AVS from mychart and give it to them. CNS-C stated after receiving the AVS from R3 they would wait for pharmacy to deliver the medication before they transcribed the orders into the eMAR for administration.	01820		

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01820	Continued From page 97 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were included in the assessment for medication management or documented in the resident record for medication or dietary supplement the resident was self-administering for one of three residents (R2). 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: R2 was admitted to the licensee on May 31, 2023. R2's diagnoses included multiple sclerosis,	01870		

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01870	Continued From page 98 neuromuscular dysfunction of bladder, unspecified, chronic constipation, frequent urinary tract infections (UTIs), and benign prostatic hyperplasia without lower urinary tract symptoms. R2's Service Plan dated June 1, 2023, indicated R2 received assistance with activities, ambulation, bathing, dressing, grooming, medication administration, catheter care, meals, and laundry. On April 21, 2025, at 1:02 p.m., the surveyor observed the following medications in R2's room: - Therawork muscle cramp foam; - Bisacodyl 10mg; - ProstaGenix (two bottles); - Polyethylene glycol 3350 oral powder; - Swiss kriss herbal laxative; and - Prostate Saw palmetto and beta sitosterol R2's medication administration record (MAR) dated April 2025, included the following: - Polyethylene glycol powder give PRN once a day as needed R2's individualized medication management plan (IMMP) dated March 12, 2025, indicated medication self-administration was not applicable, R2 could only self-administer topical for muscle cramps and suppository and R2 needed medication management and setup. The Medication Administration section of the IMMP read, "Independent-self-administer medications safely. Needs reminders to take medication" which contradicted the above self-administration medication entry. R2's undated Self Administration of Medication Assessment (SAM) printed on April 21, 2025, indicated medication self-administration was not	01870		

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01870	Continued From page 99 applicable. R2's IMMP and SAM did not indicate R2 was taking the following medications: - ProstaGenix; - Swiss kriss herbal laxative; and - Prostate Saw palmetto and beta sitosterol. On April 21, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated R2 can self-administer Vitamin A&D and R2 can self-administer the Therawork muscle cramp foam and the Bisacodyl suppository. On April 22, 2025, at 4:36p.m., CNS-C stated they were not aware R2 had the other above-mentioned medications in their room. On April 22, 2025, at 4:39 p.m., unlicensed personnel (ULP)-A stated they were aware R2 had the above-mentioned medications in their room. ULP-A stated they did inform the CNS, and CNS-C was aware of R2's possession of those medications found in R2's room. On April 23, 2025, at 12:41 p.m., CNS-C stated they were not aware of the medications the surveyor found in residents' room except the vitamin A & D, and they did not do the assessment for the above-mentioned residents, "no, I did not do it, just put medication self-administration was not done." The licensee's Storage of Medications policy indicated a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's	01870		

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01870	Continued From page 100 functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the resident that will address storage of the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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01910	Continued From page 101 licensee failed to provide documentation of disposition of medications for one of one discharged resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Discharge Resident/Client roster dated April 1, 2021, to April 21, 2025, indicated R6 was admitted to the licensee on October 6, 2024, and discharged on November 30, 2024. R6's diagnoses included liver cirrhosis Secondary to non-alcoholic steatohepatitis (NASH), gastrointestinal hemorrhage unspecified gastrointestinal hemorrhage type, Iron deficiency anemia, normocytic anemia, Meniere's Disease, gastro esophageal reflux disease (GERD), essential hypertension, obstructive sleep apnea, type 2 diabetes mellitus without complication, without long-term current use of insulin, MCI (mild cognitive impairment), and mild anxiety. R6's record included a Discharge - Transfer Summary completed by clinical nurse supervisor (CNS)-C on November 25, 2024. R6's unsigned and undated service plan indicated R6 received medication administration services. R6's Medication Administration Summary- Month for the month of November 2024, indicated R6	01910		

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01910	Continued From page 102 received the following medications: Vitamin B 12 1000 milligram (mg), ferrous sulfate 325mg, furosemide 20mg, Glucotrol XL 5mg, Lactulose 10gm/15 milliliter(ml), omeprazole 20mg, spironolactone 25mg, magnesium oxide 400mg, and simvastatin 20mg. On April 25, 2025, at 10:31 a.m., CNS-C stated they did not do medication a disposition summary for R6. CNS-C further stated the medications were R6's own medications which were brought to the facility upon admission, and they did not do medication disposition, since the medications were brought from home for respite care. The licensee's Disposition or Disposal of Medication policy read, "Drugs Given to Residents When the Medication Management Services Have Been Terminated a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. Controlled Substance a. Discontinued controlled medications that are managed by our facility will be disposed of by flushing or making non palatable per facility policy. The RN or LPN and a second person as witness will document the disposal. b. Unused portions of a controlled substance may	01910		

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01910	Continued From page 103 be given to a resident or the resident's representative upon termination of the resident's services or transfer of the resident to a health care setting if the following conditions are met; i. The controlled medications are given to the resident or the resident's representative in child resistant medication containers, unless the individual or representative requests otherwise; ii. If currently prescribed controlled drugs are released to the resident's representative, this person who, because of the resident's incapacity, makes decisions about the individual's care, must be identified in the resident record; and iii. Staff documents the release of the controlled drug medication, listing the date, medication name, quantity, strength, and dosage form of the medication; prescription number, name, address and telephone number of the dispensing pharmacy; name and signature of the person releasing the drug; and name and signature of the person receiving the controlled drug upon discharge. c. When these three conditions are not met, unused portions of a controlled substance following the termination of a resident's services will be disposed of by flushing the medication by a RN or LPN with a second person as witness. The disposal of the controlled substance must be documented in the resident's EMR or on an agency approved form." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 104 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R1) who received blood glucose monitoring.	01940		

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01940	Continued From page 105 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 was admitted to the licensee on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated August 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. R1's prescriber order signed October 18, 2022, indicated fingerstick glucose monitoring twice daily before breakfast and evening meal. R1's Individualized Treatment and Therapy Plan as of January 1, 2025, was blank and did not indicate R1's blood glucose monitoring plan. R1's Med Admin Summary - Month for the month of April 2025, indicated Accucheck blood sugar check. R1's record lacked specific instruction related to blood glucose monitoring. R1's individual treatment plan comprised of multiple documents lacked procedures for notifying a registered nurse or appropriate health professional when a problem arises with blood glucose monitoring.	01940		

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01940	Continued From page 106 On April 23, 2025, at 9:35 a.m., unlicensed personnel (ULP)-A stated they did not have specific instructions for performing blood glucose checks for R1. ULP-A stated they would call the nurse for low blood sugars, below 120 mg/dl. ULP-A stated they notify the nurse if residents had reactions like dizziness, clammy and not being able to speak properly. ULP-A further stated they provided orange juice when a resident's blood glucose was low, and they provided water when resident's blood glucose was higher than 250 or 300mg/dl. On April 23, 2025, at 11:15 a.m., clinical nurse supervisor (CNS) -C stated their expectation was for the ULPs to call the nurse for blood glucose below 70 and higher that 300mg/dl. However, CNS-C confirmed that there was no specific instruction for checking blood sugars and when to notify the nurse, and stated they usually talk with the ULPs about blood sugars. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 107 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating nursing tasks, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and failed to ensure the ULP demonstrated the ability to competently follow the procedure to perform the tasks for one of three employees (ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's signed service agreement dated Augst 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks.	01950		

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01950	Continued From page 108 ULP-H was hired on February 23, 2024, as a housekeeper. The licensee's employee schedule for the month of April 2025, indicated ULP-H was scheduled to work as a caregiver to provide direct care and services to the licensee's residents on April 1, 2025, PM shift, from 3:00 p.m., to 11:00 p.m. ULP-H's employee record included an Educare (training software) transcript dated February 28, 2024, through May 7, 2025. The transcript did not indicate ULP-H completed blood sugar check training. ULP-H's employee record lacked evidence of training or competency in administering medication and other delegated tasks including blood sugar checks. R1's Medication Administration Summary- Month for the month of April 2025, indicated ULP-H performed blood sugar checks for R1 on April 1, 2025, during the afternoon shift. On April 24, 2025, at 11:49 a.m., human resource manager (HR)-E stated ULP-H was hired as a housekeeper and later transitioned into a caregiver role. HR-E stated they were responsible for assigning trainings to both new hires and current employees. HR-E also stated it was their responsibility to make sure all employees had completed their required training before they were assigned to work independently with residents. HR-E stated ULP-H was an exception as ULP-H transitioned from a housekeeping role to caregiver role. HR-E further stated ULP-H had worked with a formerly employed licensed practical nurse (LPN) but there was no documentation to show that ULP-H was trained or deemed competent on medication administration	01950		

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01950	Continued From page 109 or other delegated tasks. HR-E further stated the nurse who worked with ULP-H reported that ULP-H was capable of doing the job. On April 24,2025, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated ULP-H primarily worked at the licensee's sister facilities. CNS-C stated ULP-H did everything that other ULPs do for the residents. On April 24, 2025, at 12:41 p.m., HR-E stated they did not know the exact date when ULP-H started working as a caregiver. HR-E further stated ULP-H was still listed as a housekeeper in Homebase (human resource software utilized by the licensee). On April 24, 2025, at 1:49 p.m., during a phone interview, ULP-H stated they were first hired as a housekeeper and then started working as a caregiver. ULP-H did not remember when they transitioned to a caregiver role. ULP-H stated they were trained on how to cook, clean, assist residents with showers, toileting, and medication administration by a nurse who was no longer employed by the licensee and other coworkers. On April 24, 2025, at 2:30 p.m., CNS-C stated they were hired after ULP-H, and they had no awareness of ULP-H's lack of training or demonstration of competency. The licensee's undated Supervision of Unlicensed Personnel policy read "1. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or Assigned Therapy Services. a. Direct Supervision of Staff Providing Delegated Tasks. Direct supervision of unlicensed staff providing delegated nursing tasks, delegated	01950		

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01950	Continued From page 110 treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. The RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies the initial period of direct supervision, the RN and/or licensed health professional will determine the frequency of ongoing, additional direct supervision based on the individual staff person's performance and on the needs and condition of individual residents, the types of services being provided and the experience of the staff. i. Supervision is designed 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. ii. The RN or appropriate licensed health professional must directly supervise staff performing medication or treatment administration. The direct supervision must include observation of the staff administering the medication or treatment and the interaction with the resident. Supervision of All Staff on All Shifts or random scheduled visits. The RN and appropriate licensed health professional will periodically provide direct supervision of staff on all shifts or random scheduled visits based on the experience and performance of the staff, the needs and conditions of the residents, and the complexity of the services being performed. The RN and appropriate licensed health professional will also consider feedback, concerns or complaints from residents and residents' representatives and information gained in resident assessments to determine if any staff needs additional direct supervision and/or	01950		

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01950	Continued From page 111 training. The RN or licensed health professional will develop a system to track direct supervision of staff to ensure that all staff is directly supervised during the year and that supervision occurs on all shifts. 2. Supervision of Unlicensed Staff Performing Services that are not Delegated by an RN or Licensed Health Professional. The RN or LALD will identify who will supervise unlicensed persons that provide services that are not delegated by an RN or a licensed health professional, such as housekeeping and laundry or other tasks defined as supportive services. These persons will be directly supervised within 30 days of beginning work and thereafter based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=I	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 provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R3) with consumer bed rails, and three of three residents (R1, R4, R5) with hospital style bed rails.	02310		

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02310	Continued From page 112 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 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: R3 R3 was admitted to the licensee on January 15, 2024. R3's diagnosis included Parkinson's disease, muscle spasm, and dystonia. R3's signed service plan dated January 15, 2024, indicated R3 received assistance with medication administration, medication set up, nail care, bathing, dressing, oral care, peri care, toileting reminders, laundry services, and safety checks. On April 21, 2025, at approximately 1:15 p.m., during a facility tour, the surveyor observed a consumer bed rail on the right side of R3's bed. R3's record included Risk Agreement- Bed Rails assessment form dated April 22, 2025, completed during the survey. The form included the following: - Resident's choice on how the situation should be handled; - Possible consequence of resident's choice; - Alternatives to minimize risk; and - Measurements of entrapment zones; R3's Risk Agreement- Bed Rails form lacked the following: - Assessment of resident's cognitive and	02310		

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02310	Continued From page 113 physical status as they pertain to bed rail to determine the intended purpose of the bed rail and whether the resident is at high risk for entrapment; - Installation and use according to manufacturer's guidelines; - Documented evidence to indicate the licensee had checked the consumer product safety commission (CSPC) website for bed rail recalls; and - Assessment of the bed rail with initial installation and with each 90-day assessment. On April 22, 2025, at 1:44 p.m., clinical nurse supervisor (CNS)-C stated the bed rail assessment was completed not upon admission/ installation of the bed rail. CNS-C stated the bed rail assessment was done today during the survey. CNS-C also stated they did not work for the licensee when R3 was admitted, and the previous nurse did not do the assessment. R4 R4 was admitted to the licensee on September 19, 2024. R4's diagnoses included Parkinson's disease, heart disease, atrial fibrillation, chronic renal insufficiency, and osteoarthritis. R4's unsigned service agreement dated May 22, 2025[sic], indicated R4 received assistance with medication administration, laundry, safety checks, bathing, and grooming. R4's most recent 90-day assessment completed on March 12, 2025, indicated no assistive device needed for bed. On April 21, 2025, at approximately 1:10 p.m., during a facility tour, the surveyor observed a hospital-style bed rail on both sides of R4's	02310		

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02310	Continued From page 114 hospital bed. R4's record lacked a bed rail assessment to include the following: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and - Bed rail assessment with each 90-day assessment. On April 22, 2025, at 3:37 p.m., CNS-C stated they did not have a bed rail assessment completed for R4. CNS-C stated they did not know why it was not done and stated the licensee had a licensed practical nurse (LPN) working when R4 was admitted. R1 R1 was admitted to the license on August 30, 2023. R1's diagnoses included morbid obesity, congestive heart failure, chronic kidney disease, hypertension, and diabetes. R1's signed service agreement dated Augst 30, 2023, indicated R1 received assistance with medication administration, medication set up, blood sugar checks, bathing, dressing, oral care, toileting, laundry services, and safety checks. On April 21, 2025, at approximately 1:05 p.m., during a facility tour, the surveyor observed a	02310		

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02310	Continued From page 115 hospital-style bed rail on both sides of R1's hospital bed. R1's record included Risk Agreement- Bed Rails assessment form dated August 30, 2023. The form included the following: - Resident's choice on how the situation should be handled; - Possible consequence of resident's choice; - Alternatives to minimize risk; and - Measurements of entrapment zones; R1's most recent 90-day assessment dated February 26, 2025, indicated R1 had half bed rails; the assessment also indicated the bed safety zones were not applicable. R1's record lacked the following: - Assessment of resident's cognitive and physical status as they pertain to bedrail to determine the intended purpose of the bedrail and whether the resident is at high risk for entrapment; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - Measurements with each 90-day assessment; and - Assessment of the bed rail with each 90-day assessment. R5 R5 was admitted to the licensee on July 5, 2023. R5's diagnosis included hypertension, chronic kidney disease, heart failure, and hypotension. R5's service plan dated July 5, 2023, indicated R5 received assistance with bathing, dressing, grooming, ambulation, and medication administration.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	24264		04/25/2025

NAME OF PROVIDER OR SUPPLIER
GOLDEN VALLEY RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE
1940 MAJOR DRIVE
GOLDEN VALLEY, MN 55422

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02310	Continued From page 116 On April 21, 2025, at approximately 1:00 p.m., during a facility tour, the surveyor observed a hospital-style bed rail on the right side of R5's hospital-style bed. R5's 90-day assessment dated March 12, 2025, indicated R5 had standard bed frame and did not indicate that R5 had a hospital-style bed with half bed rail. R5's record included Risk Agreement- Bed Rails assessment form dated July 5, 2023. The form included the following: - Resident's choice on how the situation should be handled; - Possible consequence of resident's choice; - Alternatives to minimize risk; and - Measurements of entrapment zones. R5's record lacked the following: - Assessment of resident's cognitive and physical status as they pertain to bed rail to determine the intended purpose of the bed rail and whether the resident is at high risk for entrapment; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - Measurements with each 90-day assessment; and - Assessment of the bed rail with each 90-day assessment. On April 22, 2025, at 1:54 p.m., CNS-C stated they did not know they had to do ongoing bed rail assessments. CNS-C stated they were made aware that they needed to do bed rail assessment with each 90-day assessment on a recent survey conducted at the licensee's sister facility. CNS-C also stated the previous nurse did	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	24264		04/25/2025

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02310	Continued From page 117 not complete the assessment stated, "I took over this facility on November 9, 2024." The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "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) indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 118 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 hospital bed rail should include, but is not limited to: Purpose and intention of the bed rail; Measurements; The resident's bed rail use/need assessment; Risk vs. benefits discussion (individualized to each resident's risks); The resident's preferences; 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. In addition, the MDH website indicated documentation about a resident's consumer bed rail should include, 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. For consumer bed rails, the website indicated licensees should refer to the Consumer Product Safety Commission for the most up-to-date information related to recall	02310		

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02310	Continued From page 119 information. Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subpart 2. Assessment tool elements B. (3) indicated a resident's mobility status must be assessed to include ambulation, transfers, and assistive devices. The licensee's Bedrail Assessment policy dated August 1, 2021, read, "1. Due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. 2. The resident/responsible party will be educated regarding the risks and benefits of physical devices. Physical devices will be reviewed for safety and used according to manufacturer's recommendations. 3. Continued use of physical devices will be assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility. 4. If the physical device restricts a resident's freedom of movement, it constitutes a restraint, and our facilities are restraint free. Physical devices that do not restrict the resident's freedom of movement and are used to assist the resident/client in bed mobility are not restraints. 5. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *04/22/25*
Time: 11:00:00
Report: 1047251099

Food and Beverage Establishment Inspection Report

Location:
Golden Valley Residence
1940 Major Lane
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037646
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635501774
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

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD THERMOMETER AVAILABLE ON SITE

Comply By: 04/22/25

2-100 Supervision

2-102.12AMN

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

REPEAT VIOLATION- FIRST ISSUED 4/4/23.

FACILITY DOES NOT HAVE A STATE CERTIFIED FOOD PROTECTION MANAGER. INCLUDED LINK TO STATE CERTIFICATION WITH REPORT.

Comply By: 05/22/25

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

PORK TENDERLOIN OBSERVED ON COUNTER THAWING IN AMBIENT TEMPERATURE. DISCUSSED ABOVE OPTIONS. CORRECTED ON SITE- TENDERLOIN WAS RELOCATED TO

REFRIGERATOR.
Comply By: 04/22/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BASEMENT OVEN HAD STICKY SUBSTANCE ON THE TOP OF THE DOOR AND ON OVEN DOOR HANDLE.

VENTILATION HOOD ABOVE OVEN HAD BUILD UP OF GREASE.
Comply By: 04/29/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SIGNAGE MISSING AT KITCHEN HANDWASHING SINK
Comply By: 04/29/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- burkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: Basement refrigerator- ambient
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	4

Inspection conducted with M. Egge and R. Nyamweya & reviewed with MDH Nurse Evaluator D. Mosissa.

The establishment has a residential kitchen and food serves prepared that day. The kitchen has a laminate floor, tiled & painted walls, stone/composite countertop, textured ceiling, and wood/composite cabinetry.

The facility also has a basement kitchen area with an additional freezer/refrigerator. Kitchen is not in use besides as additional storage.

A two basin sink is located in the kitchen. On sink basin should be designated for handwashing. A residential dish machine is located in the kitchen.

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning/sanitizing, serving highly susceptible populations, & food handling procedures.

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 1047251099 of 04/22/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Marilyn Egge
Operator

Signed:_____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us