DEPARTMENT OF HEALTH

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

December 1, 2022

Administrator
Golden Nest LLC
1918 19th Avenue Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL27473015

Dear Administrator:

On November 23, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 23, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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Electronically Delivered

October 27, 2022

Administrator
Golden Nest LLC
1918 19th Avenue Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL27473015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

**St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $3,000.00**
**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00**

**The total amount you are assessed is $6,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 27473 | A. BUILDING: _____ B. WING _____ | 09/23/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN NEST LLC | 1918 19TH AVENUE NE MINNEAPOLIS, MN 55418 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#SL27473015<br><br>On September 19, 2022 through September 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 residents receiving services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 115 SS=F | 144G.10 Subd. 2 Licensure categories | 0 115 | | |

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| 0 115 | Continued From page 1<br>(a) The categories in this subdivision are established for assisted living facility licensure.<br>(1) The assisted living facility category is for assisted living facilities that only provide assisted living services.<br>(2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit.<br>(b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to obtain an assisted living facility with dementia care license when the licensee's facility was secured and not all residents were not able to leave the building without staff assistance. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 1, 2022, the licensee received a license renewal from the Minnesota Department of Health (MDH) to operate as an Assisted Living | 0 115 | | |

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| 0 115 | Continued From page 2<br>facility, not as an Assisted Living with Dementia Care facility.<br><br>On September 19, 2022, at 10:00 a.m., the surveyors entered the licensee's locked facility with coded entrances and exits. Every exit in the facility was secured with a code.<br><br>During the facility tour on September 19, 2022, at 11:38 a.m., manager (M)-C indicated a unit on first floor was for dementia residents. Residents on second floor received some assistance and third floor was more independent residents.<br><br>During an interview on September 19, 2022, at approximately 11:00 a.m., M-C, stated the facility is always locked and the independent residents had the codes to exit the facility. M-C stated the facility had "dementia" residents who were a wander risk. The "dementia unit" was located on the first floor near the main entrance. M-C also stated their door security will change to key cards.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 115 | | |
| 0 340 SS=I | 144G.30 Subd. 5 Correction orders<br><br>(a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee 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.<br>(b) The commissioner shall mail or e-mail copies | 0 340 | | |

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| 0 340 | Continued From page 3<br>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.<br>(c) By the correction order date, the facility must 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate order, tag identification 2310 associated with 144G.91 Subd. 4 (a), during a survey on September 19, 2022.<br><br>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).<br><br>The findings include:<br><br>On September 20, 2022, at 2:20 p.m., the Minnesota Department of Health issued an | 0 340 | | |

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| 0 340 | Continued From page 4<br>immediate correction order under tag identification 2310 to the licensee via email.<br><br>On September 21, 2022, at 12:37 p.m., the survey concluded without the licensee's submission of a plan of correction to be taken to remove the immediacy of order 2310.<br><br>On September 21, 2022, at 3:18 p.m., the licensee responded to the immediate order email from the survey supervisor an acknowledgement of receipt of the immediate correction order.<br><br>The licensee failed to submit a plan of correction required to address the immediate order. The immediacy of correction order tag identification 2310 was not lifted.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 340 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, | 0 480 | | |

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| 0 480 | Continued From page 5<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all 18 residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated September 19, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. | 0 510 | | |

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| 0 510 | Continued From page 6<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employee, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.)<br><br>The findings include:<br><br>On September 19 through September 21, 2022, during the survey, the surveyors observed multiple employees not wearing a face mask in the proper manner while providing services to residents, including having face masks below the nose, and one employee not wearing a mask. Additionally, the surveyors did not observe employees wear eye protection at any point during the survey, including while providing cares | 0 510 | | |

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| 0 510 | Continued From page 7<br>to multiple residents.<br><br>On September 20, 2022, at approximately 8:15 a.m., unlicensed personnel (ULP)-B provided medication administration to four residents. ULP-B obtained temperature and oxygen saturation with an oximeter (device goes on finger and measures oxygen level) for each resident. ULP-B did not clean the oximeter between each resident. In addition, ULP-B did not wear eye protection at any point during medication administration.<br><br>The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection.<br><br>The CDC COVID Data Tracker on September 20, 2022, indicated Hennepin County, Minnesota (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents.<br><br>On September 21, 2022, at approximately 1:00 p.m., manager (M)-C, unlicensed personnel (ULP)-E, and ULP-F acknowledged staff were not wearing masks in the proper manner and were unaware of eye protection requirement. M-C indicated staff would start wearing eye protection in patient care areas. | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would follow guidance from the CDC.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all | 0 790 | | |

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| 0 790 | Continued From page 9<br>residents).<br><br>The findings include:<br><br>On September 21, 2022, from approximately 10:15 a.m. to 11:30 a.m. survey staff toured the facility with the manager (M)-C. During the facility tour, survey staff observed the monthly fire extinguisher inspections were not being completed by staff on any of the fire extinguishers in the facility. Survey staff explained where to find the instructions for a visual inspection on the fire extinguishers.<br><br>M-C verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and | 0 800 | | |

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| 0 800 | Continued From page 10<br>well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On September 21, 2022, from approximately 10:15 a.m. to 11:30 a.m. survey staff toured the facility with the manager (M)-C. During the facility tour, survey staff observed the following:<br><br>1. The upstairs hallway ceiling and fan were covered in lint and dust. The dust that had accumulated on the walls, ceilings, fans, pipes, and sprinkler heads was thick enough to obscure the paint color on all the listed items.<br><br>2. Closets JC-1 and JC-2 were missing cover plates on the light switches.<br><br>3. Room B-2 had water damage on the ceiling and wall above the entrance door. M-C stated she did not know of any active leaks in the building, but would look into it.<br><br>4. The ceiling on the third floor of the main stairwell had signs of possible water damage. M-C stated she did not know of any active leaks in the building, but would look into it.<br><br>5. The toilets in the women's and men's bathrooms on floor 'A' were not secured in place. | 0 800 | | |

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| 0 800 | Continued From page 11<br><br>The floor tiles were cut irregularly by the toilets and left gapping where water could get under the tile. No sealant was installed at the base of the toilets.<br><br>6. The door frame of the men's bathroom on floor 'A' was not secure in the wall and was able to be pulled out several inches from the rough opening. Nails were exposed where the frame had been pulled away from the wall.<br><br>7. The sprinkler heads in the memory care addition were covered in dust and needed to be cleaned.<br><br>8. The radiator cover in bathroom M-1 was walling off the radiator.<br><br>9. Miscellaneous items were being stored in front of the electrical boxes in the lower level. Electrical boxes need to have clear floor space in front of them for easy access.<br><br>10. Railing at the window well in the parking lot had been damaged and broken off from the concrete base. M-C stated one of her staff members had crashed into it and they hadn't gotten it fixed yet.<br><br>M-C verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment | 0 810 | | |

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| 0 810 | Continued From page 12<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans. This had the potential to affect all current residents, staff, and visitors to | 0 810 | | |

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| 0 810 | Continued From page 13<br>the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 residents).<br><br>The findings include:<br><br>During interview on September 21, 2022, at 11:30 a.m., the manager (M)-C stated she had not updated the policy from the basic policy they had bought from a third-party provider group.<br><br>Review of the "Fire Safety" policy dated August 1, 2021, showed the following:<br><br>1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=F | 144G.45 Subd. 2 (g) Fire protection and physical environment | 0 820 | | |

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| 0 820 | Continued From page 14<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee had lock hardware that required a code to exit the home on the egress side of the front and back doors. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 21, 2022, from approximately 10:15 a.m. to 11:30 a.m. survey staff toured the | 0 820 | | |

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| 0 820 | Continued From page 15<br>facility with the manager (M)-C. The facility was licensed for 24 residents. The building was a three-story, sprinklered building with nineteen rooms. During the facility tour, survey staff observed the following:<br><br>The main entrance, side dining room, and back exit doors had door hardware that required the knowledge of a code to unlock the doors and exit the building. Survey staff asked M-C if a code was required to exit the facility and M-C stated yes, her staff and most of the more independent residents know the code. She stated that the residents in the memory care addition did not know the code. Survey staff asked M-C if the door locks were tied into the fire alarm system and if they would automatically unlock if the alarm sounded or if the sprinklers went off. M-C stated no, the doors were not connected to the fire alarm or sprinkler system in any way and would remain locked if either of the life safety systems were triggered.<br><br>Survey staff explained that the doors must be available for immediate use during a fire or similar emergency for safe egress out of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 820 | | |
| 0 970 SS=C | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or | 0 970 | | |

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| 0 970 | Continued From page 16<br>should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On September 19, 2022, at approximately 10:00 a.m., manager (M)-C provided a blank Residency Agreement and indicated the document was the licensee's assisted living contract that was given to all the residents.<br><br>Under Miscellaneous Provisions, 1. Insurance Liability and Release indicated the resident acknowledges that the licensee is not an insurer of the resident's person or property. The resident agrees the licensee will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal | 0 970 | | |

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| 0 970 | Continued From page 17<br>property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of the licensee or its employees or agents.<br><br>Under the licensee's undated Exhibit 6 Resident Managed Risks document, it indicated their "staff will attempt to protect personal property, but cannot guarantee its safety."<br><br>On September 21, 2022, at approximately 1:00 p.m., M-C acknowledged the language in the identified assisted living contract for all residents, included a waiver of liability.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 970 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in | 01620 | | |

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| 01620 | Continued From page 18 | 01620 | | |

the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of two residents (R1, R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 on April 11, 2022.

On September 20, 2022, at approximately 9:15 a.m., unlicensed personnel (ULP)-B and ULP-E provided personal cares to R1.

R1's Service Plan dated April 11, 2022, indicated R1 received services to include medication

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| 01620 | Continued From page 19<br>administration, bathing, toileting assistance, mobility assistance, and meal assistance.<br><br>R1's 90-day reassessment titled Golden Nest Nurse Reassessment Visit dated July 11, 2022, lacked areas required on the uniform assessment tool including:<br>- the resident's personal lifestyle preferences,<br>- advanced health care directive, and<br>- physical health status.<br><br>R2<br>R2 was admitted on March 14, 2022.<br><br>On September 20, 2022, at approximately 8:15 a.m., ULP-B administered medications to R2.<br><br>R2's Service Plan dated March 14, 2022, indicated R2 received services to include medication administration, bathing assistance as needed, and monitoring and reassessment by a registered nurse.<br><br>R2's 90-day reassessment titled Golden Nest Nurse Reassessment Visit dated July 11, 2022, lacked areas required on the uniform assessment tool including:<br>- the resident's personal lifestyle preferences,<br>- advanced health care directive, and<br>- physical health status.<br><br>On September 21, 2022, at approximately 12:10 p.m., manager (M)-C acknowledged the licensee's nursing assessments did not include all information from the uniform assessment tool.<br><br>The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated a registered nurse would utilize a uniform assessment tool that included all | 01620 | | |

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| 01620 | Continued From page 20<br>information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01650 SS=D | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. | 01650 | | |

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| 01650 | Continued From page 21<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on March 14, 2022. R2's diagnoses included complex regional pain syndrome, depression, anxiety, and somatization disorder (mental and behavioral disorder). R2 required assistance with personal cares as needed, meals, and medication administration.<br><br>On September 20, 2022, at approximately 8:15 a.m., unlicensed personnel (ULP)-B administered medications to R2 and obtained vital signs (blood pressure, oxygen level, pulse and temperature).<br><br>R2's care plan dated August 26, 2022, indicated R2 needed assistance with medication administration, dressing, grooming, mobility, laundry, and housekeeping.<br><br>R2's September 2022 Medication Administration Record (MAR), indicated R2 received assistance with medication administration from September 1 | 01650 | | |

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| 01650 | Continued From page 22<br>through September 21, 2022.<br><br>R2's current service plan, dated March 14, 2022, lacked:<br>-a description of the services to be provided according to the resident's current assessment,<br>- medication administration,<br>-dressing,<br>-toileting,<br>-mobility,<br>-meal assistance,<br>-vital signs, and<br>-behavior.<br><br>On September 21, 2022, at approximately 1:00 p.m., manager (M)-C acknowledged the above information was not included on the service plan for R2.<br><br>The licensee's Service Plan policy dated August 1, 2021, indicated the licensee would include a description of services to be provided on the service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01650 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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 | 01730 | | |

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|---|---|---|---|
| | 27473 | A. BUILDING: _____ B. WING _____ | 09/23/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN NEST LLC | 1918 19TH AVENUE NE MINNEAPOLIS, MN 55418 |

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|---|---|---|---|---|
| 01730 | Continued From page 23<br>individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(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;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to include in the service plan an individualized medication | 01730 | | |

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| 01730 | Continued From page 24<br>management services plan with required content for one of two residents (R2) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R2 was admitted to the facility on March 14, 2022. R2's diagnoses included complex regional pain syndrome, depression, anxiety, and somatization disorder (mental and behavioral disorder). R2 required assistance with personal cares as needed, meals, and medication administration.<br><br>On September 20, 2022, at approximately 8:15 a.m., unlicensed personnel (ULP)-B administered medications to R2.<br><br>R2's September medication administration record (MAR) indicated R2 received medications by licensee from September 1 through September 21, 2022.<br><br>R2's service plan dated March 14, 2022, did not include medication management.<br><br>On September 21, 2022, at approximately 1:00 p.m., manager (M)-C acknowledged medication management was not listed on the service plan. | 01730 | | |

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|---|---|---|---|---|
| 01730 | Continued From page 25<br><br>The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services provided on the service plan.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) days | 01730 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerators.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 20, 2022, at approximately 12:45 p.m., the surveyor observed the licensee's medication refrigerator with unlicensed personnel | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 26<br><br>(ULP)-F. The surveyor observed a thermometer on the inside door of the refrigerator, but no temperature log. The refrigerator had a freezer component attached to it. The refrigerator was not locked. The refrigerator was located in a large room with two doors that locked, one door was propped open when a resident entered the area on September 19, 2022, at approximately 10:30 a.m. On September 21, 2022, at approximately 12:00 p.m., a third-party provider was in the same room as the refrigerator unattended by staff for several minutes.<br><br>The refrigerator contained:<br>-four Humalog (short acting insulin) pens<br>-one Lantus (long acting insulin) pen<br>-one Aimovig (anti-migraine) injection<br>-Sodium chloride 10ml syringes<br>-five Levemir (long acting insulin) pens<br>-one bottle of Lorazepam concentrate (anti-anxiety)<br><br>The manufacturer's instructions for Humalog dated April 2020, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit (F)). Do not allow Humalog to freeze.<br><br>The manufacturer's instructions for Lantus dated June 2022, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow Lantus to freeze.<br><br>The manufacturer's instructions for Aimovig dated September 2022, indicated before opening store the medication in original package in the refrigerator (36-46 degrees F). Do not freeze.<br><br>The manufacturer's instructions for Levemir, dated September 2022, indicated before opening store the insulin pens in the refrigerator (36-46 | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 27<br>degrees F). Do not freeze.<br><br>The manufacturer's instructions for Sodium Chloride, dated April 2008, indicated to store in room temperature between 59-86 degrees F. Do not freeze.<br><br>The manufacturer's instructions for Lorazepam Intensol oral concentrate undated, indicated to store at cold temperature (36-46 degrees F).<br><br>On September 20, 2022, at approximately 1:00 p.m., ULP-F verified no temperature log was completed by the licensee's employees, but stated the temperature was checked daily. ULP-F created a temperature log and began temperature checks.<br><br>The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated "medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." The licensee's policy also stated medications will be stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) days | 01880 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription | 01890 | | |

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| 01890 | Continued From page 28<br>label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure expired medications were properly disposed of which had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 19, 2022, at approximately 11:00 a.m., manager (M)-C, stated the licensee provided medication management to all the residents.<br><br>On September 20, 2022, at approximately 8:15 a.m., unlicensed personnel (ULP)-B administered medications to four residents.<br><br>On September 20, 2022, at approximately 8:45 a.m., the surveyor and ULP-B observed expired house stock (over the counter medications that are available for any resident with a doctors' order) medication and an improperly labeled bottle of what the licensee stated was Tylenol (analgesic for pain/fever). The prescription bottle (orange color) labeled "Tylenol 325 mg," was handwritten in black marker. The bottle lacked a | 01890 | | |

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| 01890 | Continued From page 29<br>manufacturer's label including an expiration date and instruction for use. The surveyor also observed house stock Imodium (anti-diarrheal) was past expiration date.<br><br>On September 21, 2022, at approximately 1:00 p.m., manager (M)-C acknowledged the Imodium was expired and Tylenol was improperly labeled. Those medications were removed from the medication cabinet.<br><br>The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated a licensed nurse would check medication expiration dates and reorder when necessary. The policy also indicated all over-the-counter (OTC) medications should be retained in their original, labeled container with directions for use.<br><br>The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse will identify any expired or outdated medications, which will be disposed according to policy.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=I | 144G.91 Subd. 4 Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced | 02310 | | |

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| 02310 | Continued From page 30<br>by:<br>Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R1, R3) who utilized bed rails with records reviewed.<br><br>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).<br><br>The findings include:<br><br>On September 20, 2022, at approximately 9:15 a.m., during care observation, the surveyor observed a unilateral (one side) bed rail on R1's hospital bed. In addition, the surveyor observed a upside down "U" shaped grab bar on another bed within the same room.<br><br>On September 20, 2022, at approximately 11:19 a.m., manager (M)-C acknowledged the "U" shaped grab bar was not secured as it pulled away from the bed with ease. M-C acknowledged it was not properly installed per manufacture's guidance. The surveyor observed another "U" shaped grab bar and eight (8) additional hospital side rails throughout the licensee's facility.<br><br>R1<br>R1 was admitted on April 11, 2022.<br><br>R1's Side-Rail Use Assessment Form dated April | 02310 | | |

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| 02310 | Continued From page 31 | 02310 | | |

14, 2022, indicated R1 used side rails for bed positioning and to promote independence. Additionally, it indicated the resident and resident's representative acknowledged the risk and benefits of side rail use. The assessment lacked the Food and Drug Administration (FDA) required measurement dimensions to prevent entrapment and the side rail use was not reassessed per the Uniform Assessment Tool every 90 days as required.

R1's Nurse Reassessment Visit form dated July 11, 2022, indicated no change to R1's care plan but lacked reassessment of R1's continued need for side rails and lacked safety measurements required per FDA guidance.

R3
R3 was admitted on April 11, 2022.

R3's Side-Rail Use Assessment Form dated April 11, 2022, indicated R3 used side rails for bed positioning and to promote independence. Additionally, it indicated the resident and resident's representative acknowledged the risk and benefits of side rail use but was not completed every 90 days as required.

R3's bed rail consisted of a single white wrapped metal pipe in the shape of an upside down elongated, "U," with arms extending between the box frame and mattress. There were two individual but similar styled side rails on both sides of the bed. The side rails were not securely attached to the frame of the bed. The surveyor grasped the top of the side rail and was able to easily pull the side rail out completely from between the box frame and mattress.

On September 20, 2022, at approximately 11:06

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|---|---|---|---|---|
| 02310 | Continued From page 32<br><br>a.m., registered nurse (RN)-A indicated the side rail assessments for residents with side rails lacked the required dimensions. RN-A stated R3's "U" shaped bedrail manufacturer's instructions were not available. RN-A stated they completed assessments of resident's need for side rail, but each respected assessment lacked identification of side rails being installed per manufacture's instruction and lacked assessment of side rails being secured to bedframe.<br><br>The licensee's 2.8 Side Rail Use policy dated August 1, 2021, indicated, when siderails are in use the licensee would ensure, "The side rails will be used consistent with manufacturer's recommendations," and "are of a safe design and properly maintained." The policy read, "The need for side rails will be reassessed and documented as needed, but not less than every 90 days."<br><br>The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated March 10, 2006, included the 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."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 02310 | | |

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

Type: Full
Date: *09/19/22*
Time: 11:02:58
Report: 8075221198

# Food and Beverage Establishment Inspection Report



**Location:**
Golden Nest Llc
1918 19th Avenue Ne
Minneapolis, MN55418
Hennepin County, 27

**Establishment Info:**
ID #: 0038680
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6517552836
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

**3-500B Microbial Control: hot and cold holding**
3-501.16A2 ** Priority 1 **
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Time/temperature control for safety food measured above 41 degrees Fahrenheit in two reach in coolers.
*Comply By: 09/19/22*

**2-100 Supervision**
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

No state certified food protection manager.
*Comply By: 12/19/22*

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: cooler - bean paste
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: cooler - fresh minced garlic
Violation Issued: Yes

Type: Full
Date: *09/19/22*
Time: 11:02:58
Report: 8075221198
Golden Nest Llc

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: cooler - pasta salad
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 45 Degrees Fahrenheit - Location: cooler - kimchi
Violation Issued: Yes

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

**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 8075221198 of 09/19/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed:_____
Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us