Electronically Delivered

September 26, 2023

Licensee
Goodhue Living
108 County 9 Boulevard
Goodhue, MN 55027

RE: Project Number(s) SL39127015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on September 20, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

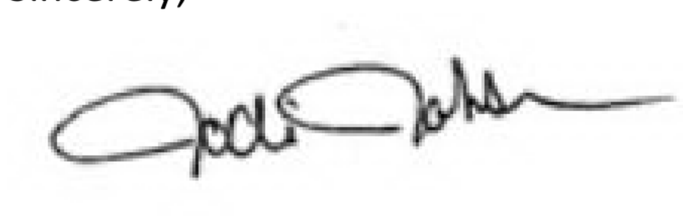
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39127015-0 On September 18, 2023, through September 20, 2023, 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 14 active residents; with 14 receiving services under the Provisional Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (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. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-E) during a blood sugar check and medication administration. 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: On September 19, 2023, at 7:25 a.m. ULP-E was observed to gather the supplies to complete R2's blood sugar check and insulin pen administration. She donned (applied) clean gloves, wiped R2's finger with an alcohol wipe, poked the finger with the lancet (the tool used to draw blood), obtained a drop of blood and placed it on the blood sugar test strip in the glucometer (a machine used to calculate a blood sugar). ULP-E held pressure	0 510		

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0 510	Continued From page 3 with a Kleenex to R2's fingertip for a few moments and disposed of the Kleenex and test strip. With the same gloves, ULP-E prepared R2's insulin pen for injection, administered the insulin, and documented the blood sugar reading and insulin administration on her tablet. ULP-E then unlocked R2's medication cupboard, put away supplies and R2's medication bucket, and relocked the medication cupboard. ULP-E finished by removing and disposing her gloves and washing her hands. ULP-E failed to remove her gloves and sanitize her hands immediately following completing R2's blood sugar check where she had potential contact with blood and touched multiple surfaces. On September 19, 2023, at 8:35 a.m. ULP-E stated she had not thought about the various surfaces she had touched following checking R2's blood sugar and the possible contamination of blood to those surfaces. On September 20, 2023, at 3:00 p.m. clinical nurse supervisor (CNS)-B stated her expectations were for the ULP to remove their gloves and sanitize their hands immediately following conducting a blood sugar check and not touch other surfaces when their hands were possibly contaminated by blood. The licensee's Handwashing policy dated August 1, 2021, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Additionally, the policy indicated hand washing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations.	0 510		

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0 510	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 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).	0 630		

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0 630	Continued From page 5 The findings include: R1 R1's diagnoses included Alzheimer's disease (a degenerative process of the brain), type 2 diabetes (when the body cannot effectively manage blood sugars and insulin production), and unspecified mood disorder. R1 was admitted to the facility on October 21, 2022. R1's Individual Abuse Prevention Plan dated November 3, 2022, indicated R1 had vulnerabilities related to chronic conditions, pain, illness, and disability; however, R1's IAPP indicated "false" in the column which identified R1's susceptibility to abuse by another individual, including other vulnerable adults. R2 R2's diagnoses included type 2 diabetes with neuropathy (nerve pain), atrial flutter, and heart disease. R2 was admitted to the facility on November 1, 2022. R2's Individual Abuse Prevention Plan dated November 3, 2022, indicated R2 had vulnerabilities related to chronic conditions, pain, illness, and disability; however, R2's IAPP indicated "false" in the column which identified R2's susceptibility to abuse by another individual, including other vulnerable adults. On September 20, 2023, at 2:00 p.m. registered nurse (RN)-D indicated she had completed the IAPP for both R1 and R2 and had interpreted the residents' susceptibility to abuse by others	0 630		

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0 630	Continued From page 6 differently. She stated she likely completed most of the other resident's IAPPs in the same manner. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the Communities would develop and implement an individual abuse prevention plan as part of the Vulnerable Adult Assessment for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	0 730		

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0 730	Continued From page 7 (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record	0 730		

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0 730	Continued From page 8 included a discharge summary with the required content for one of one discharged resident (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 began receiving services from the licensee on December 13, 2022, and was discharged to another assisted living facility on May 5, 2023. R3's discharge summary dated May 5, 2023, included R3's diagnoses, allergies, disposition of belongings, disposition of medications, pharmacy, and physician notification; however, the discharge summary lacked the required content of: - treatments and therapies; - pertinent lab, radiology, and consultation results; and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On September 19, 2023, at 3:15 p.m. regional director of operations (RDO)-B stated one of the regional nurses assisted with R3's transfer to another assisted living to be with his wife, completed the paperwork, and stated the licensee was the pilot program to a new electronic medical record system and were still figuring out all the	0 730		

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0 730	Continued From page 9 features and were working to align them to meet regulations. RDO-B reviewed the content of R3's discharge summary and stated she recognized the required content for a discharge summary was not included. The licensee's Contract Termination policy dated August 1, 2021, indicated at the time of discharge, the community would provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that included: -a summary of the resident's stay that included treatments, and therapies, and pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications, and-a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made or the resident's follow-up care, and any post-discharge medical and nonmedical services the resident would need. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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0 800	Continued From page 10	0 800		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On facility tour with the Maintenance Coordinator (MC)-F on September 19, 2023, between approximately 8:30 a.m. and 11:00 a.m., it was observed that the dining area of the memory care contained unsecured utensils that were accessible to anyone in the area. The utensils	0 800		

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0 800	Continued From page 11 were set on tables between meals and not adequately secured to ensure safety to the residents of the facility. This deficient condition was verified by MC-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (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;	01370		

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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
01370	Continued From page 12 (11) communication skills that include preserving the dignity of the resident and showing respect for 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of two unlicensed personnel (ULP-G) were completed. 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-G had a hire date of September 2, 2022, and provided direct care services under the licensee's assisted living with dementia care license. On September 20, 2023, at 2:15 p.m. ULP-G was observed interacting with R2 during an activity.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/20/2023

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GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

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01370	Continued From page 13 ULP-G's record lacked evidence of training prior to providing services for the following: -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - understanding appropriate boundaries between staff and residents and the resident's family. On September 20, 2023, at 2:30 p.m. regional director of operations (RDO)-B stated ULP-G was hired last fall and since that time, the corporate training content had been "beefed up" to include the required training content; however, ULP-G's record did not include all the required orientation content. The licensee's Orientation of Staff and Supervisors and content policy dated August 1, 2021, indicated 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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	01470		

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01470	Continued From page 14 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; (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 employee 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	01470		

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01470	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two unlicensed personnel (ULP-G). 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-G had a hire date of September 2, 2022, and provided direct care services under the licensee's assisted living with dementia care license. On September 20, 2023, at 2:15 p.m. ULP-G was observed interacting with R2 during an activity. ULP-G's record lacked documented evidence of	01470		

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01470	Continued From page 16 orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -overview of Assisted Living statutes; -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 employee will be providing and the facility's category of licensure. On September 20, 2023, at 2:30 p.m. regional director of operations (RDO)-B stated ULP-G was hired last fall and since that time, the corporate training content had been "beefed up" to include the required training content; however, ULP-G's record did not include all the required orientation content. The licensee's Orientation of Staff and Supervisors and content policy dated August 1, 2021, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 17 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 observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. 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 R2's diagnoses included type two diabetes (when the body cannot regulate its blood sugar and insulin production). R2's Service Plan dated November 1, 2022, indicated R2 received services to include	01750		

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01750	Continued From page 18 medication and insulin injection assistance. R2's provider's orders dated August 17, 2023, included glargine (insulin pen) 18 units daily. On September 19, 2023, at 7:25 a.m. ULP-E prepared R2's glargine insulin pen by removing the protective cap from the pen tip, attached a clean needle, and dialed the insulin pen to two units of insulin to "prime" the needle (remove air and ensure proper dosing would be provided). ULP-E cleansed an area on R2's lower left abdomen in preparation for insulin administration and then administered the insulin by injection and held in place for the designated six seconds (which ensured the entire dose injected). ULP-E failed to wipe the insulin pen tip prior to placing a new needle to the pen tip. On September 19, 2023, at 11:35 a.m. ULP-E stated she was not aware of the need to wipe the insulin pen tip prior to application of a new needle. ULP-E's Insulin Pen competency dated August 9, 2023, indicated ULP-E showed competency in each of the steps in insulin pen administration, including the step of wiping the insulin pen tip prior to applying a new needle. On September 20, 2023, at 3:00 p.m. clinical nurse supervisor (CNS)-B stated her expectation was for the ULP to wipe the insulin pen tip with an alcohol wipe prior to applying a new needle. The licensee's Insulin Pen procedure dated July 2021, for insulin pen, remove cap, alcohol swab end of pen and twist on safety needle. Lantus (glargine) manufacturer's instructions	01750		

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01750	Continued From page 19 dated 2022, indicated for the user to remove the flex pen cap and wipe the flex pen tip with an alcohol wipe prior to placing a new needle on the flex pen tip. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and	02110		

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02110	Continued From page 20 intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 10, 2022. R1 and R2's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values,	02110		

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02110	Continued From page 21 mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On September 19, 2023, at 2:30 p.m. regional director of operations (RDO)-B stated the licensee had developed the required dementia policies, but the admission folder and resident lease had not been updated to include the dementia policies to share with the residents or their designated representative. Furthermore, she stated none of the residents admitted to date would have received the policies. The licensee's Dementia License policy dated August 1, 2021, indicated the Dementia Policies and Procedures would be shared with residents and resident's legal representatives at the time of admission.	02110		

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02110	Continued From page 22 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *09/21/23*
Time: 12:58:22
Report: 8074231186

Food and Beverage Establishment Inspection Report

Location:
Goodhue Senior Living LLC
108 County 9 Boulevard
Goodhue, MN55027
Goodhue County, 25

Establishment Info:
ID #: 0042054
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #: 6514484055
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

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

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

Comply By: 09/25/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

floor and walls on cookline have buildup of debris.

Comply By: 09/25/23

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: internal dish machine
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *09/21/23*
Time: 12:58:22
Report: 8074231186
Goodhue Senior Living LLC

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: chili
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: memory care ambient
Violation Issued: No

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

Discussed date marking from the freezer.

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 8074231186 of 09/21/23.

Certified Food Protection Manager Sydney Melson

Certification Number: FM116481 Expires: 02/04/26

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us