



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 29, 2025

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

RE: Project Number(s) SL27473016

Dear Licensee:

On November 13, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 15, 2025 survey.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

Sincerely,

A handwritten signature in black ink, reading "Casey DeVries". The signature is written in a cursive, flowing style.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN NEST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL27473016-1 On November 12, 2025, through November 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 15, 2025. At the time of the survey, there were 23 residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180). The licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors.	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 12, 2025, at 10:35 a.m., the surveyor requested the licensee's staffing plan from CNS-Q. CNS-Q stated they had never developed or signed a staffing plan and if a staffing plan was located, it was developed under the previous CNS who no longer worked for licensee. On November 12, 2025, at 10:37 a.m., licensed assisted living director (LALD)-D stated licensee's staffing plan was stored in a different location of the facility and they would retrieve it. LALD-D left the lower level where the surveyor and CNS-Q were speaking and went to the main level. LALD-D returned within one minute with the licensee's daily schedule which had been posted at the main entrance of the facility. LALD-D provided the licensee's staffing policy and daily schedule and stated the documents were the licensee's staffing plan. No staffing plan was developed and implemented by a CNS which addressed the required content of a staffing plan per Minnesota Administrative Rule 4659.0180. The licensee's Staffing policy dated April 13,	{0 470}			

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{0 470}	Continued From page 3 2023, indicated a CNS would develop and implement a staffing plan to address the needs of the residents, which included the reasonably foreseeable needs of each resident. No further information was provided.	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	{0 480}			

Minnesota Department of Health
STATE FORM 6899 2V8U12 If continuation sheet 5 of 9

Minnesota Department of Health

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{01440}	Continued From page 5 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of six unlicensed personnel ((ULP)-A). 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-A was hired on June 17, 2025, to provide assisted living services to residents.	{01440}			

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{01440}	Continued From page 6 ULP-A's Home health Aide Medication Competency Evaluation and Additional Home Health Aide Competency Evaluation Skills documents both dated August 22, 2025, indicated ULP-A was trained, found competent, and was delegated nursing task from a RN. ULP-A's record lacked evidence a RN completed a 30-day supervision of ULP-A performing delegated nursing tasks. On November 12, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-Q stated the licensee was aware ULPs required a 30-day supervision visit for delegated nursing tasks. CNS-Q stated ULP-A worked weekends only and CNS-Q had a difficult time coordinating time to complete the 30-day supervision but was aware the supervision was required. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision of ULPs who performed delegated tasks would be completed and documented within 30 days. No further information was provided.	{01440}			
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	{01530}			

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{01530}	Continued From page 7 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to provide two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of six unlicensed personnel ((ULP)-A).	{01530}			

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{01530}	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-A was hired on June 17, 2025, to provide assisted living services to residents. ULP-A's Orientation Checklist dated June 17, 2025, was identified by clinical nurse supervisor (CNS)-Q as ULP-A's list of completed orientation documentation ULP-A had received since they were hired. The checklist lacked identification ULP-A received any orientation or training related to mental illness requirements. On November 12, 2025, at 1:00 p.m., CNS-Q stated the licensee had been actively training all employees on mental illness training, but ULP-A's training had not been completed and documented yet. CNS-Q stated the licensee was aware all staff were required to have the two hours of mental illness training completed by July 1, 2025, but the licensee had not completed all the training yet. The licensee lacked a policy to address the required mental illness training requirements. No further information was provided.	{01530}			



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September 12, 2025

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

RE: Project Number(s) SL27473016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services - \$1,000.00
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$1,000.00
St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - \$1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00
St - 0 - 1420 - 144g.62 Subd. 2 - Delegation Of Assisted Living Services - \$1,000.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - \$1,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$1,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$13,000.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

To submit a hearing request, please visit:

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

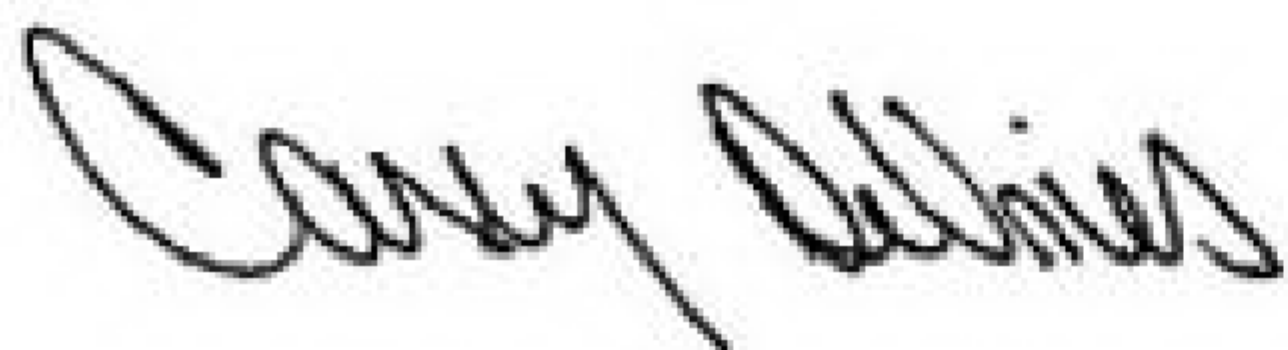
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" being more prominent than the last name "DeVries".

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

HHH

Minnesota Department of Health

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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: SL27473016-0 On August 11, 2025, through August 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 22 residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on August 11, 2025, issued for SL27473016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on August 12, 2025, issued for SL27473016-0, tag identification 0470. During the survey, the licensee took action to mitigate the immediate	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN NEST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 000	Continued From page 1 risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on August 13, 2025, issued for SL27473016-0, tag identification 1620. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 14, 2025, issued for SL27473016-0, tag identification 0495. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 14, 2025, issued for SL27473016-0, tag identification 1750. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 15, 2025, issued for SL27473016-0, tag identification 1420. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 15, 2025, issued for SL27473016-0, tag identification 0775. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 15, 2025, issued for SL27473016-0, tag identification 0820. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on	0 000			

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0 000	Continued From page 2 August 15, 2025, issued for SL27473016-0, tag identification 1820. During the survey, the licensee did not take sufficient action to mitigate the immediate risk. An immediate correction order was identified on August 15, 2025, issued for SL27473016-0, tag identification 1950. During the survey, the licensee did not take sufficient action to mitigate the immediate risk.	0 000			
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (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. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain an assisted living facility with dementia care license when the licensee provided dementia care services, and utilized a lock to secure an area of the facility so residents could not exit the locked door without removing the eye hook lock at the top of the door. This had the potential to affect all residents in the lower level of the facility.	0 115			

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0 115	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility received an assisted living facility license effective August 1, 2021, for a capacity of 24 residents. The licensee most recently renewed their application in April 2025 and had a renewed license granted effective June 1, 2025. On August 13, 2025, at approximately 10:35 a.m., the surveyor asked unlicensed personnel (ULP)-B who was sitting in the dining room with residents, to go in R1 and R2's room along with surveyor. After the surveyor and ULP-B went in the resident's room together, when the surveyor tried to leave the unit, the surveyor noted the door to exit the unit to another area of the building was locked with a black hook and eye lock which was installed at 69 inches from the finished floor. The surveyor inquired to ULP-B why the door was locked and ULP-B stated they locked the door because R6 has tried to leave without staff supervision in the past. On August 13, 2025, at approximately 3:45 p.m., the surveyor went upstairs to return to the above-mentioned unit and was unable to enter as the door was locked from the other side. ULP-K opened the door for the surveyor. ULP-K stated they locked the door because they were changing	0 115			

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0 115	Continued From page 4 a resident who required two persons assist and so that R6 did not exit during that time. On August 13, 2025, at 1:41 p.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-C stated R6 wanders, which was why the door was locked. LALD-D stated the licensee also used a camera/monitor so they could watch R6 after-hours. LALD-D stated R6 was never left alone and always needed one to one supervision. When asked, LALD-D state they did not think R6 needed a secure care facility but did need continuous one on one supervision. R6's Resident Assessment dated, July 17, 2025, included a section labeled Vulnerability which indicated, "[R6] has a dx [diagnosis] of late onset Alzheimer/dementia Staff will provide supervision and monitoring 24/7." The licensee was previously cited for the same deficient practice following an initial full survey conducted September 19, 2022, through September 21, 2022. The licensee's Unsafe Assisted Living Situations policy dated, August 1, 2021, indicated, "It is the responsibility of [Licensee] to assess the level of safety in an assisted living care plan, and wherever possible resolve safety concerns. The process will ensure that the staff has taken adequate steps to consider both the resident's autonomy (right to make decisions) and the need for the assisted living facility to act benevolently (do good)." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	0 115			

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0 115	Continued From page 5 days	0 115			
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the assisted living facility. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 had an assisted living license, effective August 1, 2021. The licensee most recently renewed their application in April 2025 and had a renewed license granted effective June 1, 2025.	0 420			

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0 420	Continued From page 6 The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner on April 18, 2025. As a result of this survey, the following orders were issued under tag identification numbers 0115, 0470, 0480, 0495, 0550, 0570, 0650, 0660, 0680, 0775, 0810, 0820, 0830, 0910, 0970, 1290, 1360, 1410, 1420, 1440, 1530, 1560, 1620, 1640, 1750, 1790, 1810, 1820, 1830, 1870, 1950, 1960, 2410, and 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.	0 420			

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0 420	Continued From page 7	0 420			
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient	0 470			

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0 470	Continued From page 8 staffing to meet the needs of two of two residents (R1, R2) who required two-person transfers with a mechanical lift. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 lacked sufficient staffing to meet R1 and R2's needs on a 24-hour basis as required by the resident assessment and service plan. The licensee's current staffing plan dated October 17, 2023, indicated the licensee had two staff present for all three meals and two staff present for all transfers for activities of daily living (ADLs) for non-ambulatory residents. The plan indicated the staffing requirements included two direct care staff for morning shift, two direct care staff for evening shift, and one awake and one on-call staff person for night shift. The licensee's staffing schedule dated August 11 through August 17, 2025, indicated unlicensed personnel (ULP)-F was a back-up staff for overnight shift (10:00 p.m., to 7:00 a.m.,) on the following days: August 11, 12, 14, 15, 16 and 17. The staffing schedule did not indicate a backup staff for August 13. ULP-F was listed to work the overnight shift on August 17, 2025, and ULP-F was also listed as the back-up staff on the same day. The licensee's undated employee roster only had one person by the ULP-F's name.	0 470			

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0 470	Continued From page 9 R1 R1's diagnoses included hemiplegia, hyperlipidemia, mild cognitive impairment, dementia, hypertension, and diabetes mellitus. R1's service plan, dated April 25, 2025, indicated R1 required a two-person assist for all transfers. The service plan read "Back up staff plan each night shift staff on call for assist with transfers as needed." R1's 90-day nursing reassessment form, dated June 19, 2025, indicated R1 was totally dependent and required an assist of two persons for transfer with a mechanical lift. The assessment also indicated the resident would require two persons assist to safely evacuate during an emergency. R2 R2's diagnoses included type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavioral disturbance, altered mental status, and adult failure to thrive. R2's service plan, dated November 15, 2024, indicated R2 required a two-person assist for all transfers. The service plan read "Back up staff plan each night shift staff on call for assist with transfers as needed." R2's 90-day nursing reassessment form, dated June 26, 2025, indicated R2 required an assist of two persons for transfer with a mechanical lift. The assessment also indicated the resident would require two persons assist to safely evacuate during an emergency. On August 11, 2025, at approximately 11:00 a.m.,	0 470			

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0 470	Continued From page 10 during the entrance conference, licensed assisted living director (LALD)-D stated one (unlicensed personnel) ULP was scheduled to work the night shift from 10:00 p.m., to 7:00 a.m. On August 12, 2025, at 11:44 a.m., ULP-E stated there was one person scheduled to work overnight and directed the surveyor to the daily schedule posted on the wall which indicated two ULPs and one lead staff for 1st shift, two ULPs for 2nd shift, and one ULP for 3rd shift. On August 12, 2025, at 12:19 p.m., clinical nurse supervisor (CNS)-C stated they had one ULP scheduled for overnight with another ULP who lives close by if needed. On August 12, 2025, at 12:25 p.m., licensed assisted living director (LALD)-D stated they had one staff scheduled for overnight. LALD-D stated in case of an emergency they had three staff who lived five minutes away from the facility who could come in and help. Minnesota Administrative Rule 4659.0180 Subp. 5., read. "Direct-care staff availability. A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The licensee's staffing policy revised April 13, 2023, read "At least two (2) home health aides will be scheduled and available for residents requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs as reflected in the assessment and service plan."	0 470			

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0 470	Continued From page 11	0 470			
	No further information was provided.				
	TIME PERIOD FOR CORRECTION: Immediate				
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 12 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 480			

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0 480	Continued From page 13 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated clinical nurse supervisor	0 495			

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0 495	Continued From page 14 (CNS)-C was currently performing the role of the clinical nurse supervisor for the licensee. On August 13, 2025, at 11:07 a.m., previous clinical nurse supervisor (P/CNS)-G stated if residents requested a PRN (as needed) medication on the overnight shift, the staff called LALD-D, and sometimes LALD-D would go in and administer the medication. On August 13, 2025, 11:36 a.m., CNS-C stated she was not hired to be on-call. CNS-C verbalized she found out from LALD-D during the survey entrance conference that she was supposed to be on-call for the licensee. In addition, CNS-C stated she was told by LALD-D, P/CNS-G was still actively employed by the licensee and was the on-call nurse for the licensee. On August 13, 2025, at 11:44 a.m., P/CNS-G stated, via phone, she was not currently employed by the licensee but would occasionally work at their other licensed location. P/CNS-G stated since she was not on-call for the licensee then there was no nurse on-call for the licensee at this time. During this conversation, LALD-D was also present and stated the employees called her when there was a concern after hours, and if it was a nursing related question, LALD-D would call P/CNS-G or provide direction for the employee to call 911 if it was an emergency. On August 13, 2025, at 12:06 p.m., unlicensed personnel (ULP)-M stated, they would call LALD-D or manager (M)-H after hours, and if an emergency, they would call 911. ULP-M verbalized it was done this way at the facility because it was easier to communicate with LALD-D and M-H because of a language barrier with CNS-C.	0 495			

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0 495	Continued From page 15 On August 13, 2025, at 12:07 p.m., ULP-B stated after hours they called LALD-D. When asked, ULP-B stated, they have not called the nurse after hours. On August 13, 2025, at 12:15 p.m., CNS-C provided a timecard document indicating the last day P/CNS-G worked at the facility was July 9, 2025. On August 13, 2025, at 12:16 p.m., P/CNS-G stated, via phone, when she worked with the licensee, staff would call LALD-D and then LALD-D would call her if it was nursing related. On August 13, 2025, at 12:37 p.m., CNS-C, provided an email sent by them on July 2, 2025, at 12:05 p.m., to a consultant which indicated, "2. Supposedly, [P/CNS-G] is the "on call nurse" or at least her name is written on the form that hangs up in the kitchen. However, employees always told staff to call either [M-H] or [LALD-D], not [P/CNS-G]. [P/CNS/G] and [M-H] live far away afrom (sic) here. Additionally, [P/CNS-G] does not even work here anymore per [LALD-D]. The consultant's response, identified in the email by a different color text indicated, "Their process has been to call [LALD-D] (or [M-H]) 1st. Then they determine whether or not to call the RN. If you seen (sic) any discrepancies in this, please talk with [LALD-D]." In addition, CNS-C, provided another email sent July 31, 2025, at 9:23 p.m., to a consultant documenting, "[P/CNS-G] doesn't work at [Licensee] anymore. I worked with her 2 days." On August 14, 2025, at 10:34 a.m., during an interview with LALD-D and CNS-C, LALD-D	0 495			

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0 495	Continued From page 16 stated she planned to have CNS-C provide on-call nursing coverage for the facility. CNS-C verbalized she did have this conversation with LALD-D yesterday (August 13, 2025), but the change in her position had not been documented or reviewed with her yet. The licensee's Supervision: Unlicensed Staff policy, dated August 1, 2021, indicated, "1. A Registered Nurse (RN) is available for consultation to staff: a. The RN is available either in person, by phone or by other means 24 hours/day, 7 days/week. b. Staff are instructed regarding the system for accessing consultation during orientation and as needed or when change occur." The licensee's Staffing policy dated, August 1, 2021, indicated, "5. Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, awake home health aide staff will respond to resident requests for assistance as soon as possible." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for	0 550			

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0 550	Continued From page 17 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 11:30 a.m., during a facility tour, the surveyor observed contact information for the Minnesota Adult Abuse Reporting Center posted on a bulletin board in the hallway by the main entrance. The surveyor did not observe the following throughout the facility: - OMHDD; and	0 550			

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0 550	Continued From page 18 - a notice to indicate, if an individual has a complaint about the facility or person providing services, the individual may contact the OHFC at the Minnesota Department of Health. On August 11, 2025, at 1:25 p.m., licensed assisted living director (LALD)-D stated they were not aware the above-mentioned information needed to be posted in the facility. LALD-D stated the residents had the information on the bill of rights they received. The licensee's Grievance policy dated August 21, 2021, indicated a copy of the grievance procedure would be conspicuously posted and included the contact information for OMHDD and OHFC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a	0 570			

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0 570	Continued From page 19 violation that will cause only 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 held an assisted living license effective June 1, 2025, with an expiration date of May 31, 2026. On August 11, 2025, at 11:30 a.m., the surveyor did not observe a posted license in the facility's common areas. Licensed assisted living director (LALD)-D stated the license was posted in their locked office. LALD-D stated they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650			

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0 650	Continued From page 20 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of four employees (unlicensed personnel (ULP)-K). 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-K was hired on April 1, 2024, to provide assisted living services. ULP-K's personnel file included a personal care assistant (PCA) training certificate dated July 23, 2024. ULP-K's personnel file lacked the following	0 650			

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0 650	Continued From page 21 required content: - training: - documentation requirement for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, oral prosthetic devices, hearing aids, dressing, toileting; - prevention of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - communication skills; - understanding appropriate boundaries; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting resident status; - basic knowledge of body functioning and changes in the body functioning; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs; - safe transfer techniques and ambulation; and - range of motion and positioning. - competency evaluation: - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, oral prosthetic devices, hearing aids, dressing, toileting; - standby assistance techniques and how to perform them;	0 650			

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0 650	Continued From page 22 - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. - annual training: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policy and procedures; and - principles of person-centered planning/service delivery. On August 14, 2025, at 12:34 p.m., ULP-K stated they were trained on the topics listed by the supervisor and by watching videos. ULP-K stated they were competency evaluated by their supervisor who was not a nurse on the topics listed above. ULP-K stated they received annual training on the topics listed above by the supervisor. Although ULP-K indicated they received competency evaluations, the competency evaluations were completed by an inappropriate personnel member. See order 1360. On August 14, 2025, at 11:50 a.m., licensed assisted living director (LALD)-D sated, "My understanding I know he (ULP-K) did all the education, but it is missing like you say." LALD-D stated they believed ULP-K's PCA certificate was what kept the licensee in compliance with the	0 650			

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0 650	Continued From page 23 competency evaluations. The licensee's Personnel Records policy dated August 1, 2021, indicated a personnel record would include annual training, documentation of orientation, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention	0 660			

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0 660	Continued From page 24 (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-F, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment form dated April 28, 2025, indicated the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on June 17, 2025, to provide assisted living services to residents. ULP-A's employee record included a chest x-ray completed November 20, 2023, indicating ULP-A was negative for TB. ULP-A's record lacked a correlating TB test result and lacked a TB health history screening. ULP-B ULP-B was hired on April 1, 2025, to provide assisted living services to residents. On August 13, 2025, at 9:34 a.m., the surveyor observed ULP-B complete a wound treatment to R1.	0 660			

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0 660	Continued From page 25 ULP-B's employee record included a TB health history screening dated July 6, 2023, first step TST completed May 22, 2023, and a second step TST completed July 10, 2023. Although ULP-B's record included two TST skin tests, the TST's were completed farther apart than the CDC's recommendations for how to complete a two-step TST. ULP-F ULP-F was hired on September 23, 2024, to provide assisted living services. On August 13, 2025, from 9:34 a.m., to 9:57 a.m., the surveyor observed ULP-F and ULP-B transfer R1. ULP-F's employee record included a chest x-ray completed September 24, 2024, indicating ULP-F was negative for TB. ULP-F's record lacked record lacked a correlating TB test result and lacked a TB health history screening. ULP-K ULP-K was hired on April 1, 2024, to provide assisted living services. ULP-K's employee record included a one-step TST test completed March 9, 2022. ULP-K's record lacked a second step TST or other evidence of TB screening such as a blood test and lacked a TB health history screening. On August 14, 2025, at 10:42 a.m., clinical nurse supervisor (CNS)-C stated they had been employed with the licensee for a month and there had not been any new employees hired since they started. CNS-C stated before an employee starts employment, they should have two negative TSTs, or if a TST was positive they	0 660			

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0 660	Continued From page 26 would need to have a chest x-ray. CNS-C stated the results would have to be kept in the employee's personnel file. CNS-C stated the surveyor would need to talk further to LALD-D because they did not know the employees. On August 14, 2025, at 11:23 a.m., LALD-D stated upon hire they request employees provide the licensee with a two-step TST and if the TST was positive the employee would go to the hospital for a chest x-ray. LALD-D stated the licensee did not provide TB testing. LALD-D stated some employees were of Asian descent and the employee knew they would test positive when they completed a TST so the employee would just complete a chest x-ray. LALD-D stated they do not complete health history screenings upon hire, and they believed the health history screening only needed to be completed if an employee was positive for TB or experienced symptoms of TB. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQ) dated July 1, 2025, read, "A CXR [chest Xray] alone is not acceptable documentation. You either need - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and - a CXR with provider evaluation after that date or - documentation of refusal of both the two-step TST and IGRA - followed by a new CXR and provider evaluation. If the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR	0 660			

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0 660	Continued From page 27 needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date." The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; - a TB test which could include TB blood test or TB skin test; and - additional evaluation for TB disease as needed. In addition, if the TST was used for baseline testing of healthcare personnel it would use two-step testing. The CDC's Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test dated January 31, 2025, indicated if the first TB skin test result was negative a second TB skin test should be completed one to three weeks later. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680			

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NAME OF PROVIDER OR SUPPLIER GOLDEN NEST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 680	Continued From page 28 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. 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	0 680			

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0 680	Continued From page 29 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP revised July 2021, lacked evidence of the following required content: - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; and - role under waiver declared by secretary. On August 14, 2025, at 2:55 p.m., licensed assisted living director (LALD)-D stated they were not aware the missing items mentioned above were required to be included in the EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775			

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0 775	Continued From page 30 failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. SPRINKLER SYSTEM: The sprinkler system had a tag that indicated that it was last serviced on 8/7/24. Water-based automatic fire extinguishing systems shall be inspected and tested annually. LALD-D stated that the contractor was scheduled to come out and service the sprinkler system. No proof of contractor being scheduled for service was provided. At 11:15 a.m. on August 12, 2025, the surveyor requested the most recent copy of the facility's annual sprinkler report. No report was provided. Records of all system inspections, tests and maintenance required by the referenced standards shall be maintained.	0 775			

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0 775	Continued From page 31 In the lower-level common hallway, and furnace/laundry room of the addition to the building was lacking a ceiling, and the surveyor was able to see the engineered trusses and sub flooring of the first floor. In some areas plastic sheeting had been installed on the bottom of the trusses. The engineered trusses were approximately 12 inches high, and the deflector of the sprinkler head was approximately 4 inches below the bottom of the truss. The deflector of the sprinkler head was approximately 16 inches below the hard surface for heat collection. The lack of a proper heat collection point can cause the sprinkler system to not activate properly increasing potential of fire loss and increasing danger to the occupants. The distance from the sprinkler deflector and the hard surface for heat collection shall not exceed 12 inches. FIRE ALARM: The annunciator panel for the fire alarm system located near the front door to the facility on the north side of the building had an amber colored light indicating that the fire alarm was silenced. LALD-D stated that they were not sure what the amber light on the fire alarm meant, but they believed that they alarm was functional. At 11:15 a.m. on August 12, 2025, LALD-D provided a copy of the annual fire alarm report dated December 10, 2024. The fire alarm report had a deficiency listed for smoke detector location of L2 that failed. There is also a note in the report that the customer says they have a trouble that comes up on this once in a while.	0 775			

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0 775	Continued From page 32 Failure to maintain the fire alarm in an operational condition can result in delay of fire department notification and increase the potential for fire loss and increase danger to the occupants. Fire and life safety systems shall be maintained in an operable condition at all times. FIRE DOOR OPERATION: There were several listed fire doors that would not close, and latch automatically located in the following locations: second floor south side leading from the common corridor to the protected stairwell, in the basement leading to the mechanical room. The listed fire door on the first-floor north side leading from the corridor to the protected stairwell was being held in the open position with a wooden wedge. There was also a baby gate installed in the doorway that swung in both directions. The gate was found open into the stairwell. When the surveyor attempted to close the propped fire door the baby gate obstructed the door from closing and latching on its own. LALD-D stated that the baby gate is for a resident that wanders, and that the door is normally closed. LALD-D stated that they believed that staff had propped the door earlier in the day when delivering breakfast to residents. Fire doors that do not operate as designed increase fire and smoke spread increasing the danger of smoke inhalation and fire related injuries to the occupants. Swinging fire doors shall close from the full-open position and latch automatically	0 775			

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0 775	Continued From page 33 IMPROPER LOCKING: On the first floor of the addition the door that leads from the resident common area to the corridor was equipped with a lockable handle. The handle was installed so that the thumb turn was on the corridor side of the door and if locked occupants would need a key to exit the area. On the first floor of the addition the door that leads to the parking lot was equipped with a keyed hasp lock with a twist knob. LALD-D stated that the lock is not operational, and that they do not use it. On the first-floor north side the main exit door was equipped with a keyed hasp lock with a twist knob, and a keyed brass rim lock. On August 12, 2025, during the facility tour the engineering surveyor observed that the lower-level door in the addition leading to the east was equipped with a normal lockable handle with a thumb latch and a deadbolt. On August 13, 2025, at 8:39 a.m. the nurse surveyor observed that a child safety lock had been installed over the lockable handle after the engineering surveyor had conducted the physical environment facility tour. Improper locking increases occupants time to exit or can completely prohibit exiting the building which can lead to serious injury or death. Egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. HARDWARE HEIGHT: On the first floor of the addition the door that	0 775			

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0 775	Continued From page 34 leads from the resident common area to the corridor was equipped with a hook and eye lock that was installed at 69 inches from the finished floor. On the first floor of the addition the door that leads to the parking lot was equipped with a keyed hasp lock with a twist knob that was installed at 71 inches from the finished floor. On the first-floor north side the main exit door was equipped with a keyed hasp lock with a twist knob installed at 68 inches from the finished floor, and a keyed brass rim lock installed at 63 inches from the finished floor. Hardware installed at improper height on egress doors increases occupants time to exit or can completely prohibit exiting the building which can lead to serious injury or death. Additional observations of the use of the hook and eye lock provided by the nurse surveyor are as follows: On August 13, 2025, at approximately 10:35 a.m. the surveyor asked ULP-B who was sitting in the dining room with residents, to go in R1 and R2's room along with surveyor. The surveyor and ULP-B went in the resident's room together, when the surveyor tried to leave the unit, the surveyor noted the door was locked with black hook and eye lock installed at 69 inches from the finished floor. The surveyor inquired ULP-B why the door was locked and ULP-B stated they locked the door because R6 likes to get up and move and has tried to leave without staff supervision in the past. On August 13, 2024, at approximately 3:45 p.m., the surveyor went upstairs to the above-mentioned unit and was unable to enter as	0 775			

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0 775	Continued From page 35 the door was locked from the other side. ULP-K opened the door for the surveyor. ULP-K stated they locked the door because they were changing a resident who required two persons assist and so R6 did not exit. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches minimum and 48 inches maximum above the finished floor. TIME PERIOD FOR CORRECTION: Immediate	0 775			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810			

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0 810	Continued From page 36 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following:	0 810			

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0 810	Continued From page 37 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. LALD-D stated that the resident actions are all verbal instructions and that there is no place in the policy that has specific actions for residents to take in the event of a fire or similar emergency. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Drill documentation provided by LALD-D indicated that they were conducting training and not drills. LALD-D agreed that they train employees during the "drills" and lacked clear documentation that evacuation drills had been conducted. Drills shall be conducted twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820			

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0 820	Continued From page 38 (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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide and maintain a safe and compliant electrical system. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed.	0 820			

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0 820	Continued From page 39 In the mechanical room of the facility there was a light switch that was screwed directly to a piece of door trim and not installed in an approved junction box with a switch cover. The wiring for the light switch was not encased in conduit and was run through a hole in the top of the door trim and was hooked into a light fixture inside of the file room. LALD-D stated that they were not aware that the light switch was an issue since it has not been mentioned before. While attempting to prove that the outlet was secure LALD-D reached out and grabbed the outlet and wiggled it. LALD-D suddenly pulled their hand back. LALD-D stated that they had gotten an electrical shock from the light switch when they touched the sides of the switch. The electrical wiring and light switch being installed in a non-code compliant manner presents the potential for both electrocution hazard to people as well as the risk of fire from improper installation. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	0 830			

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0 830	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 12, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. In the lower level of the addition in the common hallway near the furnace/laundry room there was a drainpipe that was cut off about 12 inches from the floor above. The surveyor could see up through the pipe and could see daylight of the room above. The drainpipe appeared to be attached to a floor drain in the bathroom above. LALD-D stated that their plumber had cut the pipe off and a new floor drain was installed. LALD-D didn't believe that it was a problem since they had covered the floor drain that had a cut off drain with clear plastic and no water would go down the	0 830			

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0 830	Continued From page 41 drain. Plumbing shall be installed and maintained in an approved manner. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 910			

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0 910	Continued From page 42 The findings include: R1 R1 was admitted on June 7, 2024, and had diagnoses including history of a stroke with left sided hemiplegia (paralysis), depression, and abnormal weight loss. R1's Assisted Living Contract signed on June 7, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the licensee. R2 R2 was admitted to the licensee on November 14, 2024, and had diagnoses including type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavioral disturbance, altered mental status, and adult failure to thrive. R2's Assisted Living Contract signed on November 14, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. The licensee's blank assisted living contract lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. On August 14, 2025, at 12:47 p.m., licensed assisted living director (LALD)-D stated they bought the assisted living contract form from a consultant, and they trusted the consultant's expertise to include all the required information. No further information was provided.	0 910			

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0 910	Continued From page 43	0 910			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (R1). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on June 7, 2024, with diagnoses including history of a stroke with left sided hemiplegia (partial or total paralysis), depression, and abnormal weight loss. R1's Service Plan and Home Health Aide Care	0 970			

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0 970	Continued From page 44 Plan dated, April 25, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, dressing, grooming, bathing, toileting, transfers, behavior management, and medication administration. R1's Assisted Living Contract dated June 17, 2024, included the following language indicating waivers of liability: "Miscellaneous Provisions 1. Insurance health, Liability personal and property, Release. The resident shall maintain at all and times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [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 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 [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." On August 13, 2025, at 11:20 a.m., licensed assisted living director (LALD)-D stated she was not aware of the waiver of liability language requirement, and they used this contract for all the licensee's residents.	0 970			

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0 970	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for one of 17 employees (unlicensed personnel (ULP)-A). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a	01290			

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01290	Continued From page 46 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-A was hired on June 17, 2025, to provide direct cares and services to residents. The licensee's staffing schedule for August 11, 2025, through August 17, 2025, indicated ULP-A was scheduled to work the day shifts (7:00 a.m. to 3:00 p.m.) for the following dates: August 16 and August 17. The licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) printed on August 11, 2025, did not include ULP-A's name under employees whose background checks were clear. On August 11, 2025, at approximately 1:20 p.m., the surveyor reviewed the NETStudy 2.0 website which indicated ULP-A was separated from the licensee due to no consent on June 24, 2025. On August 11, 2025, at 1:32 p.m., licensed assisted living director (LALD)-D stated they had completed the BGS application and paid for ULP-A to go get fingerprinted. LALD-D stated they knew ULP-A was fingerprinted but they did not follow through to check if ULP-A's BGS was cleared. LALD-D also stated ULP-A had been working without supervision. The licensee's Personnel Records policy dated August 1, 2021, read, "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the	01290			

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01290	Continued From page 47 following are kept in the personnel record, as applicable to job requirements: - o Evidence of current professional licensure, registration or certification - o Results of background studies - o Records of annual training and infection control training - o Documentation of orientation - o Documentation of supervision, as applicable - o Performance reviews - o Competency evaluations - o Signed job description - o Documentation of annual performance reviews identifying areas of improvement needed and training needs 3. A job description is maintained that includes qualifications, responsibilities and identification of supervisors for each job classification. 4. Each personnel record shall be maintained for at least three years after an employee, home care volunteer or contractor ceases to be employed by or under contract with Golden Nest. The Director/Owner will arrange for safe storage in the event that the agency is closed. 5. Results of required health screening and medical examinations will be maintained in a separate, private file." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted	01360			

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01360	Continued From page 48 living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) provided training and competency evaluations of unlicensed personnel (ULP) providing assisted living services for three of four unlicensed personnel ((ULP)-A, ULP-B, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-K ULP-K was hired on April 1, 2024, to provide assisted living services. ULP-K's personnel file lacked the following competency evaluations to be completed by a RN: -standby assistance techniques and how to perform them;	01360			

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01360	Continued From page 49 -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. On August 14, 2025, at 12:34 p.m., ULP-K stated they were competency evaluated by their supervisor who was not a nurse on the topics listed above. ULP-A and ULP-B ULP-A was hired on June 17, 2025, to provide assisted living services to residents. ULP-B was hired on April 1, 2025, to provide assisted living services to residents. ULP-A and ULP-B's Home Health Aide Competency Evaluation dated June 18, 2025, and April 2, 2025, respectively, indicated a ULP, manager (M)-H, signed ULP-A and ULP-B off as competent on the following topics: - bathing; - haircare/shampoo; - oral hygiene; - dressing; - toileting; - hearing aids; - stand-by assist; - handwashing; - temperature - pulse and respiration; - skin and nail care; - safe transfer technique/ambulation; - positioning; - range of motion; - treatments as delegated; - confidentiality and respect for privacy/property; - communication skills; - recording and documenting;	01360			

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01360	Continued From page 50 - professional boundaries; - cultural diversity; - medication/exercise/treatment; - fall prevention; - infection control; - basic nutrition, meal preparation, food safety, assistance with eating; - recognizing emergencies; - commonly used health technology equipment and assistive devices; - maintenance of a clean, safe, and healthy environment; - observing, recording and documenting; - basic knowledge of body functioning; and - physical emotional, emotional, cognitive and developmental needs. Although ULP-A and ULP-B received the competency evaluations listed above, the following competency evaluations were required to be completed by a RN, or another instructor may provide training in conjunction with the RN unless the employee was a certified nursing assistant (CNA). - standby assistance techniques and how to perform them; - reading and recording temperature, pulse and respirations of a resident; - safe transfer techniques and ambulation; - range of motion and positioning; - administering medications or treatments as required; and - other RN professionally delegated tasks like catheter, stoma care, Broda, mechanical lifts. On August 14, 2025, at 10:44 a.m., clinical nurse supervisor (CNS)-C stated they did not know how staff were trained CNS-C stated, "I know there is supervision and monitoring involved but I have not had a chance to start that process." CNS-C	01360			

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01360	Continued From page 51 stated there were meetings once per month. On August 14, 2025, at 10:56 a.m., CNS-C stated "If you have issues with the employee record talk to [licensed assisted living director (LALD)-D]. I have only been here a month." On August 14, 2025, at 11:31 a.m., LALD-D stated the licensee used the document listed above for their 30-day supervision and it was usually completed by M-H. The surveyor inquired what document the licensee then used for orientation of the ULP. LALD-D stated they also used the document listed above. LALD-D stated M-H was a CNA. LALD-D stated they believed the items on the document listed above could be completed by a ULP. LALD-D stated they knew medication training had to be completed by a RN. The surveyor explained the competency evaluations which needed to be completed by a RN. LALD-D stated they were not aware of that requirement. On August 14, 2025, at 11:35 a.m., LALD-D stated their normal practice was that competency evaluations were completed by either LALD-D, the site manager who was a ULP, or a nurse. On August 15, 2025, at 11:03 a.m., CNS-C stated they had been asking about competency evaluations since they started, and the licensee's management had not provided them with any information. The Staff Competency policy dated August 1, 2021, indicated the CNS was responsible for the overall competency evaluation program. Individual instructors for competency evaluation would be experienced in home health care and appropriately qualified for the level of staff being	01360			

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01360	Continued From page 52 evaluated based on the following: - education and competency testing of all staff (unlicensed personnel) providing basic home care services through the licensee would be administered by staff with experience and education in the provision of the basic home care services. - education and competency testing for ULP providing comprehensive home care services would be administered by a RN or qualified instructor as delegated by the RN. - competency testing of licensed health professionals would be conducted by a similarly licensed clinician. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360			
01410 SS=F	144G.62 Subd. 2 Delegation of assisted living services (a) A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences.	01410			

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01410	Continued From page 53 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and implement a system to communicate up-to-date information to the registered nurse (RN) regarding the current available staff and their competency. This affected all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated the licensee employed two nurses. On August 13, 2025, at 11:44 a.m., previous clinical nurse supervisor (P/CNS)-G stated, via phone, they were not currently employed by the licensee but would occasionally work at their other licensed location. Clinical nurse supervisor (CNS)-C was hired on July 1, 2025, to provide oversight to unlicensed personnel (ULP) and provide assisted living services to residents. On August 14, 2025, at 10:39 a.m., CNS-C stated the licensee hired them one month ago however,	01410			

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01410	Continued From page 54 their job description was not for the clinical nurse supervisor position. On August 14, 2025, at 10:44 a.m., CNS-C stated they had been unable to locate competency evaluations for the unlicensed personnel (ULP). CNS-C stated, "I know it is the nurse's responsibility to make sure they [ULP] are fully trained." On August 15, 2025, at 11:03 a.m., the surveyor inquired what system the licensee had in place to communicate up-to-date information to the RN regarding the current available staff and their competencies, so the RN had sufficient information to determine the appropriateness of delegating tasks to ULP to meet the resident's needs. CNS-C stated, "I have not seen a system, and no I have not been trained on a system for competency evaluations. I have been there less than a month." CNS-C stated they had been asking about competency evaluations since they started, and the licensee's management had not provided them with any information. During the survey the licensee was issued the following immediate orders 1420, 1750, 1950. These orders were all related to competency evaluations. The licensee's Delegation of Assisted Living Tasks policy dated August 1, 2021, indicated the RN or licensed health professional was responsible for appropriately delegating tasks to staff who were competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The RN or licensed health professional would have access to the ULP personnel files or other reports to	01410			

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01410	Continued From page 55 determine level of competence prior to delegation of any tasks so that up-to-date information about current available staff and their competency was available to have sufficient information to determine the appropriateness of delegating tasks to meet the resident's needs and preferences. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01410			
01420 SS=I	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to provide training and competency evaluations by a registered nurse (RN) to unlicensed personal (ULP) for delegated	01420			

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01420	Continued From page 56 catheter cares and full body mechanical lifts for four of four employees (ULP-A, ULP-B, ULP-F, ULP-K). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on June 7, 2024, and had diagnoses including history of a stroke with left sided hemiplegia (paralysis), depression, and abnormal weight loss. R1's Service Plan signed April 25, 2025, indicated R1 received "catheter care Q [every] shift & [and] empty" and transfer assist of two (staff) with full body mechanical lift. On August 13, 2025, at 8:55 a.m., the surveyor observed ULP-B and ULP-F transfer R1 with a Snap America brand mechanical lift utilizing a sling from R1's wheelchair to her shower chair. ULP-B moved R1's catheter from her wheelchair to the shower chair during the transfer. On August 13, 2025, from 9:34 a.m., to 9:57 a.m., the surveyor observed ULP-B and ULP-F transfer R1 from lying supine (on the back) in her bed to R1's wheelchair using a sling with the full body mechanical lift. In addition, ULP-B moved the catheter bag from R1's bed to her wheelchair during the transfer.	01420			

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NAME OF PROVIDER OR SUPPLIER GOLDEN NEST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1918 19TH AVENUE NE MINNEAPOLIS, MN 55418		
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01420	Continued From page 57 On August 14, 2025, at 1:15 p.m., ULP-B showed the surveyor the documentation of R1's foley catheter bag being emptied. The document was titled Shift Communication Tool which was used for multiple residents. The shift communication tool indicated R1's foley catheter bag was last drained of 1200 milliliters (ml) on August 13, 2025, and 50 ml on August 14, 2025. There were no instructions on how to properly clean the foley catheter bag within the documentation or within R1's record. On August 14, 2025, at 1:20 p.m., ULP-M stated the employees only emptied the catheter bag and provided no other cares related to the foley catheter for R1. ULP-M verbalized R1 would have her catheter changed periodically by her provider. R1's medical record included a signed provider SOAP (subjective, objective, assessment, plan) note, dated, July 24, 2025, indicating R1's indwelling foley catheter was replaced. ULP-A was hired on June 17, 2025, to provide assisted living services. ULP-B was hired on April 1, 2025, to provide assisted living services. ULP-F was hired on September 23, 2024, to provide assisted living services. ULP-K was hired on April 1, 2024, to provide assisted living services. ULP-A, ULP-B, ULP-F, and ULP-K's personnel files did not contain training or competency evaluations for catheter care or full body mechanical lifts.	01420			

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01420	Continued From page 58 On August 14, 2025, at 10:39 a.m., clinical nurse supervisor (CNS)-C stated it was not in their job description to be a CNS for the licensee. CNS-C stated there was a resident with a catheter in the facility which ULP provided care for and there were people who required full body lifts. On August 14, 2025, at 10:54 a.m., CNS-C stated they were unable to find documentation of competency evaluations for ULP completed for full body mechanical lifts and catheter cares. On August 14, 2025, at 11:00 a.m., licensed assisted living director (LALD)-D stated employees completed hands on training for two to three days, a competency evaluation on the skill, and then could shadow with other coworkers. LALD-D stated if more time was indicated for training the licensee would provide it. On August 14, 2025, at 11:40 a.m., LALD-D stated a nurse watched ULP complete catheter care and mechanical full body lifts. LALD-D stated they did not have documentation of the training or competency evaluation for any employees. On August 14, 2025, at 12:46 p.m., ULP-K stated they provided catheter care, and they transferred residents with a full body lift. ULP-K stated they were trained on the catheter and mechanical full body lift by manager (M)-H (a non-RN). On August 14, 2025, at 1:08 p.m., ULP-B stated they provided catheter care and transferred residents with a full body lift and were trained by a certified nursing assistant (CNA). ULP-B was unable to name the CNA. On August 14, 2025, at 1:50 a.m., ULP-A stated	01420			

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01420	Continued From page 59 they were instructed to clean and empty the catheter. ULP-A stated they were trained by two or three other ULP and M-H. ULP-A stated they transferred residents with the full body lift. ULP-A stated they were trained by ULP and M-H for the mechanical full body lift as well. On August 14, 2025, at 1:59 p.m., the surveyor attempted to contact ULP-F for an interview. The surveyor did not receive a return phone call. The licensee's Delegation of Assisted Living Tasks dated August 1, 2021, indicated the RN or licensed health professional was responsible for appropriately delegating tasks to staff who were competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The RN or licensed health professional would have access to the employee's personnel files or other reports to determine level of competence prior to delegation of any task so that up-to-date information about current available staff and their competency was available to have sufficient information to determine the appropriateness of delegating tasks to meet the resident's needs and preferences. In addition, a ULP who provided delegated nursing services were orientated by a RN or licensed health professional prior to initiation of the service. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01420			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440			

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01440	Continued From page 60 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-F, ULP-K). 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	01440			

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01440	Continued From page 61 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on June 17, 2025, to provide assisted living services to residents. On August 14, 2025, 1:50 p.m., ULP-A stated they completed catheter care, water flushes on a tube feeding, and transferred residents with a mechanical lift. ULP-B ULP-B was hired on April 1, 2025, to provide assisted living services to residents. On August 13, 2025, at 9:34 a.m., the surveyor observed ULP-B complete a wound treatment to R1. On August 14, 2025, at 1:07 p.m., ULP-B stated they complete water flushes on a tube feeding and transfer residents with mechanical full body lift. ULP-B stated they received a 30-day supervision by manager (M)-H, an unlicensed employee. ULP-B stated M-H provided them with feedback on their performance. ULP-F ULP-F was hired on September 23, 2024, to provide assisted living services. On August 13, 2025, from 9:34 a.m., to 9:57 a.m., the surveyor observed ULP-F and ULP-B transfer R1 with a mechanical full body lift. On August 15, 2025, at 10:48 a.m., ULP-F stated	01440			

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01440	Continued From page 62 they complete water flushes on a tube feeding, and catheter care. ULP-K ULP-K was hired on April 1, 2024, to provide assisted living services. On August 14, 2025, at 12:45 p.m., ULP-K stated they passed medication to residents. ULP-K stated they did not receive a 30-day supervision. ULP-A, ULP-B, ULP-F, and ULP-K's employee records lacked a 30-day supervision. On August 14, 2025, at 10:44 a.m., clinical nurse supervisor (CNS)-C stated, "I know there is supervision and monitoring involved but I have not had a chance to start that process." On August 14, 2025, at 10:56 a.m., CNS-C stated "If you have issues with the employee record talk to [licensed assisted living director (LALD)-D]. I have only been here a month." On August 14, 2025, at 11:31 a.m., LALD-D stated supervisions of ULP were usually conducted by M-H. LALD-D stated M-H was a CNA. LALD-D stated the licensee used the document titled Home Health Aide Competency Evaluation to document employee's 30-day supervision. The surveyor inquired what the licensee then used for orientation documentation. LALD-D stated they used the Home Health Aide Competency Evaluation document. The surveyor observed the document and there was no indication on the form that it was used for 30-day supervisions. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct	01440			

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01440	Continued From page 63 supervision of home health aides performing delegated tasks would be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed	01530			

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01530	Continued From page 64 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for two of four employees (ULP-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated employee roster indicated the licensee had 17 employees. ULP-A	01530			

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01530	Continued From page 65 ULP-A was hired on June 17, 2025, to provide assisted living services to residents. ULP-A's record lacked training on mental illness and de-escalation. ULP-B ULP-B was hired on April 1, 2025, to provide assisted living services to residents. ULP-B's record lacked training on mental illness and de-escalation. On August 14, 2025, at 11:20 a.m., LALD-D stated the licensee trained employees on mental health and de-escalation two months ago when a registered nurse (RN) consultant came into the facility and trained the employees for two hours. On August 14, 2025, at 11:57 a.m., LALD-D provided the surveyor with a document titled Mental & Behavioral Health Management Course which indicated 11 of the 17 employees received a three hour in person training May 30, 2024. ULP-A and ULP-B were not listed on the training record. The licensee's policies did not address the new statutory requirement to provide mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01560 SS=F	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De-	01560			

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01560	Continued From page 66 (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received the required content for dementia care training for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-F). 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	01560			

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01560	Continued From page 67 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on June 17, 2025, to provide assisted living services to residents. ULP-A's record included an Orientation Checklist dated June 17, 2025, which indicated ULP-A completed eight hours of dementia training within 160 hours on June 17, 2025. The document did not indicate the course content that ULP-A received on dementia. ULP-B ULP-B was hired on April 1, 2025, to provide assisted living services to residents. ULP-B's record included an Orientation Checklist dated April 1, 2025, which indicated ULP-B completed eight hours of dementia training within 160 hours on April 8, 2025. The document did not indicate the course content that ULP-B received on dementia. ULP-F ULP-F was hired on September 23, 2024, to provide assisted living services. ULP-F's record included an Orientation Checklist dated September 23, 2024, which indicated ULP-F completed eight hours of dementia training within 160 hours on October 10, 2024. The document did not indicate the course content	01560			

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01560	Continued From page 68 that ULP-F received on dementia. On August 14, 2025, at 11:12 a.m., licensed assisted living director (LALD)-D stated at hire the licensee provided eight hours of dementia training and they provided two hours annually to employees. LALD-D stated they had a consultant who provided dementia education to employees and provided the licensee with educational material to train their employees with. LALD-D stated the licensee also used YouTube to assist with training. LALD-D provided the surveyor with a document titled Dementia and stated it was what the licensee provided for their dementia education. The content included an explanation of dementia, problem solving with challenging behaviors, and communication skills, however lacked assistance with activities of daily living, and person-centered planning. The surveyor asked LALD-D to demonstrate where they trained on the two topics listed above. LALD-D stated they did not have the two topics listed above in their training content. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must have completed at least eight hours of initial education withing 160 working hours of the employment start date in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560			

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01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620			

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01620	Continued From page 70 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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) completed an assessment on an assistive device, and the potential for it being a restraint for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on June 7, 2024, and had diagnoses including history of a stroke with left sided hemiplegia (paralysis), depression, and abnormal weight loss. R1's unsigned Service Plan and Home Health Aide Care Plan, dated April 25, 2025, indicated R1 received assistance with housekeeping, meals, laundry, dressing, grooming, bathing,	01620			

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01620	Continued From page 71 transfers with a mechanical lift, and medication administration. On August 13, 2025, at 9:34 a.m., the surveyor observed unlicensed personnel (ULP)-B provide wound skin care and a mechanical lift transfer for R1 from the bed to R1's wheelchair. ULP-B placed a harness belt over R1's head and secured the belt near the seat of R1's wheelchair. ULP-B also secured a lap/seat belt attached to the wheelchair across R1. ULP-B stated the caregivers always use the harness and lap/seat belt for safety when R1 was in the wheelchair. When asked, ULP-B verbalized R1 had not experienced any falls that she was aware of, but the harness helped to keep R1 in the chair. R1's nursing assessment dated June 19, 2025, included a section labeled "Safety," which noted "No fall reported since last nursing visit, Resident will require A02 [assist of two] assist to safely evacuate to safety in the event of an emergency." In addition, section labeled "activity level/Mobility: Includes {sic} side rails, as applicable, indicated, "Resident is WC dependent and requires an AO2 staffs for all transfers using hoyer lift. Resident is fully dependent on staffs for assistance with ADLs. Resident have side rails present." R1's record lacked an assessment on the wheelchair harness and lap/seat belt being used daily by R1. In addition, there was no documentation of a risk versus benefit discussion with the resident or resident's representative. On August 13, 2025, at 10:50 a.m., licensed assisted living director (LALD)-D stated R1 was discharged from the transitional care unit when she moved to the facility and was admitted to the facility with the wheelchair including the harness	01620			

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01620	Continued From page 72 and safety belt. LALD-D verbalized the harness and lap/seat belt were used for safety and they did not have the manufacturer's directions for them. On August 13, 2025, at 11:16 a.m., previous clinical nurse supervisor (P/CNS)-G stated, via phone call, she was not aware R1 had a harness being used on the wheelchair for R1. On August 13, 2025, at 11:30 a.m., LALD-D provided a copy of the Reliable Medical wheelchair manual order for R1. The wheelchair order did not include information on the secured harness and lap/seat belt being used. On August 13, 2025, at 1:53 p.m., manager (M)-H provided the manufacturer directions for R1's wheelchair. The BodiLink Head Support operational manual revised September 24, 2024, included information on the wheelchair but did not contain information about the harness and lap/seat belt connecting to the wheelchair. On August 13, 2025, at 3:26 p.m., clinical nurse supervisor (CNS)-C stated she had not yet assessed R1's harness and lap/seat belt for the potential for strangulation or restraint since she started employment with the licensee a month ago. M-H who was also present stated she was not aware of any prior interventions attempted for R1 to keep her from slipping out of the wheelchair. The Minnesota Department of Health (MDH) Facility Certification, Regulation and Licensing website dated November 10, 2022, titled, Safety Without Restraints: A New Practice Standard for Safe Care, indicated, "Physical restraints have been used to remind individuals not to get up	01620			

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01620	Continued From page 73 without assistance. However, there are often newer and safer techniques available. Restraints are sometimes useful as a temporary measure in providing needed medical treatment - such as intravenous medications, specialized feedings or wound care - during the assessment period, or when other less restrictive measures have failed to provide adequate safety. Applying physical restraints routinely or for prolonged periods should be avoided whenever possible. Restraint use often leads down a slippery slope of increased dependence and disability. Research conducted from the 1980's onward suggests that restraints are more likely to cause harm than prevent it. Restraints may cause strangulation, and lead to muscle loss and bone weakness. Restrained individuals often feel humiliated. They may become depressed, withdrawn or agitated when freedom of movement is taken away from them. Restraints pose special risks for people who are agitated, or who may fall while attempting to escape their restraints." The site defined restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." Additionally, "Restraints are considered a form of medical treatment. As such, they can only be used under the direction of a physician. In ordering the use of restraints, the physician must specify the medical reason for using the device, the circumstances under which it can be used, and the length of time over which it can be used. Because of the potential dangers involved, restraint use must be monitored, and its effectiveness must be continuously evaluated. An effort must always be made to use the least restrictive available method of restraint, and to restore each individual to his or her maximum	01620			

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01620	Continued From page 74 possible level of independence." The licensee's 2.7 Restraint policy, dated, August 1, 2021, indicated, "It is the policy of [Licensee] to not use manual or chemical restraints under any circumstance." The licensee's 2.18 Equipment Safety policy, dated August 1, 2021, indicated, "1. When a resident is admitted to [Licensee] the RN notes any equipment used by him or her. The equipment supplier, if known, is documented in the clinical record. 2. The equipment is inspected by staff before use to assure that it is clean and in good working order. 3. The manufacturer's specifications and guidelines are followed for equipment operation and safety." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640			

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01640	Continued From page 75 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the resident, or their representative, documenting agreement on the services to be provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted June 7, 2024, and had diagnoses including left-sided hemiplegia (muscle weakness or partial paralysis) post cerebral vascular accident (a stroke), type two diabetes, and major depressive disorder. On August 13, 2025, at 8:55 a.m., to 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-F assist R1 with personal cares	01640			

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01640	Continued From page 76 and transfer R1 from her wheelchair to a shower chair. R1's Service Plan dated April 25, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, dressing, grooming, transfers, behavior management, catheter care, and medication administration. R1's service plan lacked authentication by the resident, or their representative, documenting agreement on the services to be provided. On August 13, 2025, at 11:20 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-C stated they were not aware of the required service plan content and requirement for authentication by resident or resident's representative. LALD-D stated they may have missed getting authentication of R1's service plan by the resident's representative. The licensee's Service Plan policy dated August 1, 2021, indicated, "4. The initial service plan and any revisions are signed by a representative from Golden Nest and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:	01750			

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01750	Continued From page 77 (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and evaluate the ULPs' ability to competently perform the task for five of five employees (ULP-F, ULP-J, ULP-K, ULP-L, licensed assisted living director (LALD)-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: LALD-D was hired on July 5, 2005, to oversee the daily operations of the facility. LALD-D was also the owner of the facility. ULP-F was hired on September 23, 2024, to provide direct cares and services to residents.	01750			

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01750	Continued From page 78 ULP-J was hired on September 24, 2024, to provide direct cares and services to residents. ULP-K was hired on April 1, 2024, to provide direct cares and services to residents. ULP-L was hired on October 10, 2019, to provide direct cares and services to residents. R1's medication administration record (MAR) dated August 1, 2025, through August 13, 2025, indicated ULP-K assisted R1 with medication administration on August 1, 3, 4, 5, and 6, 2025, and ULP-L assisted R1 with medication administration on August 7, 2025. The licensee's employee schedule dated August 11- August 17, 2025, indicated ULP-F was scheduled to work overnight shift (10:00 p.m.-7:00 a.m.) on August 13, and 17, 2025, and ULP-J was scheduled to work overnight shift (10:00 p.m.-7:00 a.m.) on August 11, 12, 14, and 15, 2025. On August 13, 2025, at 10:05 a.m., clinical nurse supervisor (CNS)-C stated if residents requested as needed medications on the overnight shift, none of the ULPs were trained, nor competency tested to administer medications. CNS-C stated they were told by LALD-D that ULPs were supposed to call LALD-D or manager (M)-H if residents request as needed medication on the overnight shift. CNS-C stated they just started working for the licensee, and they were planning to train all ULPs on how to pass medication. The employee records for LALD-D, ULP-F, ULP-K, ULP-J, and ULP-L all contained no medication administration competencies.	01750			

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01750	Continued From page 79 On August 13, 2025, at 10:29 a.m., ULP-F stated they did not pass medication, nor were they trained to do medication administration. ULP-F further stated they did do feeding tube flushes for R2 when they worked overnight shifts but no medication administration. On August 13, 2025, at 11:07 a.m., previous clinical nurse supervisor (P/CNS)-G stated if residents requested as needed medication on an overnight shift, the staff called LALD-D and sometimes LALD-D would go in and give the medications. P/CNS-G stated they did not train LALD-D on medication administration as LALD-D was already working at the licensee before the P/CNS-C was hired. On August 13, 2025, at 11:09 a.m., P/CNS-G stated they did not remember training ULP-F as ULP-F worked along with another ULP. On August 13, 2025, at 11:28 a.m., LALD-D stated they usually got a call from the ULPs if a resident requested for an as needed medication. LALD-D stated they could access the eMAR (electronic medication administration record) from home and they would give direction to the ULPs to administer the as needed medication requested if the medication was listed on the eMAR. On August 13, 2025, at 12:33 p.m., LALD-D stated they would chart the medication administration on the eMAR after the ULP gave the medication to the resident. LALD-D also stated they believed there was only one person who was not trained, and they would fix that. On August 13, 2025, at 3:15 p.m., LALD-D stated	01750			

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01750	Continued From page 80 they did not have medication competency completed for themselves or ULP-J. LALD-D stated if it was not in the employee record then it was not done. On August 13, 2025, at 3:24 p.m., LALD-D stated maybe the nurse forgot to do a competency check for ULP-K, if it was not on the employee record then it was not done. LALD-D stated they did not know why competencies for the ULPs were not done. R3's MAR dated August 1, 2025, through August 14, 2025, indicated R3 had the following as needed medication: - Nitroglycerin 0.4 milligram (mg) tablet sublingual, place one tablet under the tongue every five minutes for chest pain, up to three tablets as needed. R4's MAR dated August 1, 2025, through August 14, 2025, indicated R4 had the following as needed medication: - Lorazepam (benzodiazepine) 0.5mg tablet every six hours as needed for anxiety; - Morphine (opioid analgesic) 100mg/5ml give 5mg by mouth every three as needed for pain/dyspnea; and - Nitroglycerin 0.4mg tablet sublingual place one tablet under the tongue every five minutes for chest pain up to three tablets as needed. On August 14, 2025, at 1:10 p.m., CNS-C stated the ULPs did not how to administer the as needed medication to R4. CNS-C stated they would call the hospice nurse to come and administer them to R4. On August 14, 2025, at 1:24 p.m., the surveyor observed R4's morphine bottle sealed, with a 1ml	01750			

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01750	Continued From page 81 syringe to use for drawing the morphine. The label on the morphine bottle read Morphine 100/5ml, take 0.25ml/5mg orally every three hours as needed for shortness of breath/pain. On August 14, 2025, at 1:34 p.m., hospice nurse (H/RN)-N stated they mainly rely on the licensee's staff to administer the as needed medication unless there was hospice crisis needs required by the resident. The National Library of Medicine webpage for Nitroglycerin last updated July 31, 2023, identified Nitroglycerin as a vasodilatory drug. The site indicates, "the dose is repeatable every 5 minutes until the achievement of relief. If anginal [chest] pain persists after three doses, prompt medical attention is required." Additionally, "When administered sublingually, nitroglycerin's effectiveness is typically measured via the resolution of symptoms; angina, hypertension, and congestive heart failure. In the event of overdose, monitoring vital signs may be necessary to monitor the hemodynamic effects of nitroglycerin. Continuous monitoring of blood pressure, heart rate, respiratory rate, and oxygen saturation is recommended." The National Library of Medicine webpage for Lorazepam last updated May 25, 2024, indicated under Signs and Symptoms of Overdose, "Lorazepam can cause CNS and respiratory depression in overdose, potentially leading to hypotension, ataxia, confusion, coma, extreme drowsiness, muscle weakness, and death." The National Library of Medicine webpage for Morphine last updated March 27, 2025, indicated under Warnings and Precautions, "Morphine oral solution comes in multiple concentrations. Care	01750			

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01750	Continued From page 82 must be taken to avoid confusion between milligrams and milliliters, which can result in overdose. Always use the provided calibrated oral syringe to ensure accurate dosing, particularly with the high-concentration formulation." Additionally, under Signs and Symptoms of Overdose, "Morphine can potentially be a lethal medication when not used properly.[46] This medication causes a host of symptoms related to CNS depression. Severe respiratory depression is the most feared complication of morphine in cases of overdose. Acute morphine overdose can present with a variety of symptoms, including respiratory depression, skeletal muscle flaccidity, cold and clammy skin, hypoglycemia, bradycardia, hypotension, constricted pupils, pulmonary edema, somnolence progressing to coma, partial or complete airway obstruction." The licensee's Staff Competency policy dated August 1, 2021, read, "4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process: a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. Refer to the Competency Manual for criteria. b. Home Health Aides may not work for Golden Nest until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: i. Observation, reporting and documenting of resident status ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iii. Recognizing physical, emotional, cognitive and	01750			

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01750	Continued From page 83 development needs of the resident iv. Basic infection control, including blood-borne pathogens v. Maintenance of a clean and safe environment vi. Falls prevention xii. Communication skills and barriers xiii. Cultural diversity xiv. Confidentiality/privacy xv. Professional boundaries xvi. Handling of emergencies xvii. Commonly used health technology equipment and assistive devices vii. Safe transfer techniques and ambulation viii. Range of motion and positioning ix. Administering medications or treatments as required x. Basic nutrition, meal preparation, food safety and assistance with eating xi. Preparation of modified diets demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790			

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01790	Continued From page 84 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790			

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01790	Continued From page 85 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (unlicensed personnel (ULP)-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-K was hired on April 1, 2024, to provide assisted living services. ULP-K's employee record lacked documentation of training and a competency evaluation for unplanned time away from home. On August 14, 2025, at 10:54 a.m., clinical nurse	01790			

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01790	Continued From page 86 supervisor (CNS)-C stated they did not know how the licensee trained, or competency evaluated for unplanned times away for medication. On August 14, 2025, at 11:35 a.m., licensed assisted living director (LALD)-D stated ULP were trained to take the bubble pack of medication, place it into a zip lock bag, and provide it to the resident leaving the facility on a leave of absence. LALD-D stated training and competency evaluations for unplanned times away from home were completed by LALD-D, the site manager who was a ULP, or a RN. LALD-D stated they did not have documentation for training or a competency for ULP-K. LALD-D stated training and competency evaluations were completed on paper. The surveyor inquired where they would document this in any employee record. LALD-D stated, "I am learning I need to document." On August 14, 2025, at 12:34 p.m., ULP-K stated they were trained on providing medications to residents leaving the facility however, they were not competency evaluated. ULP-K stated "The supervisor told us how to do that. I told her the nurse should cause otherwise there is miscommunication. I told them I can't prep the medication. I told them the nurse should, but [LALD-D] said you have to know the medication when they are not there. I have prepped it twice but most the time it is the supervisor or the nurse." The licensee's Medication Documentation policy dated August 1, 2021, indicated when medication administration was delegated to a ULP, the clinical record and/or personnel files would contain documentation of appropriate competency, education, and orientation.	01790			

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01790	Continued From page 87 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790			
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications including dietary supplements and over-the-counter (OTC) drugs were stored as deemed appropriate by the resident's medication assessment for one of one 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 10:30 a.m., during the	01810			

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01810	Continued From page 88 entrance conference, licensed assisted living director (LALD)-D stated all residents at the facility received assistance with cares and medication administration. R3 was admitted to the licensee on July 8, 2024. R3's diagnoses included hypertension, carcinoma (bladder), orthostatic hypotension, insomnia, syncope, gastric esophageal reflex disease, and low backpain. R3's Service Plan dated April 25, 2025, indicated R3 received assistance with activities, mobility, dressing, grooming, toileting, assistance with meals, medication administration, catheter care, meals, and housekeeping. R3's Medication Assessment form dated July 23, 2025, indicated the following: - R3 required staff assistance with reminders for when medications are due and required staff assistance with medication usage. No supplements or as needed (PRN) medications should be stored in R3's room with exception of Nitro sublingual (SL); - R3 required staff assistance with eye drop administration; - R3 needed assistance with reading medication name and dosage; - R3 needed assistance with what each medication was for; and - Staff will continue to provide assistance with all medication needs and administration. R3's Medication Administration Record (MAR) dated from August 1, 2025, to August 31, 2025, included the following: - nitroglycerin (Nitrostat) 0.4 milligram (mg), place one tablet under the tongue every five minutes as needed for chest pain;	01810			

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01810	Continued From page 89 - acetaminophen (extra strength) 500 mg, take one tablet by mouth every six hours PRN; - cetirizine 10 mg, 1 tablet daily as needed; - aspirin chewable 81mg, take one tablet daily; and - Systane (artificial tears) 0.4% - 0.3%, place one to two drops into both eyes 4 times daily PRN for dry eyes. On August 14, 2025, at 11:54 a.m., the surveyor observed the following medications in R3's room: - aspirin 81 mg enteric coated tablets; - allergy relief cetirizine 10mg; - acetaminophen 500 mg; - lubricating eye drop; - Centrum silver women 50+ multivitamin; - fish oil 1400 mg; - Seirogan herbal dietary supplement; and - Three unknown pills in a CVS pharmacy pill bottle. Although R3's assessment indicated no supplements or PRN medications should be stored in R3's room with exception of Nitro sublingual (SL), R3 had the above listed supplements and medications stored in their room. On August 14, 2025, at 11:42 clinical nurse supervisor (CNS)-C stated they were aware R3 had Tylenol in their room, and they informed R3 they should not self-administer medications. On August 15, 2025, at 1:00 p.m., CNS-C stated they did not know R3 had the above-mentioned medications in their room except for Tylenol. On August 15, 2025, at 1:02 p.m., CNS-C stated none of the residents were assessed and deemed competent to administer their own	01810			

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01810	Continued From page 90 medication. On August 15, 2025, at 2:03 p.m., licensed assisted living director (LALD)-D stated they knew R3 had Tylenol and vitamins in their room. LALD-D stated R3's family member who lives out of state sends the medication for R3 and they deliver it to R3. LALD-D stated they believed R3 was cognitively ok to self-administer. LALD-D stated the licensee staff did not administer vitamins and stated the licensee staff only administered R3's medications that were prescribed by the doctor. On August 15, 2025, at 2:06 p.m., LALD-D stated the previous CNS informed them that residents could not have medications in their room, but family members brought those medications in. LALD-D stated residents had the right to have the medications and stated the licensee could not take them away. On August 15, 2025, at 2:10 p.m., LALD-D stated they were not aware there should be self-administration medication assessments (SAM) for residents who wished to administer their own medication. On August 13, 2025, at 12:37 p.m., CNS-C, provided an email sent by them on July 2, 2025, at 12:05 p.m., to a consultant which indicated, "Can residents keep medications in their room? There are a few residents that have medications in room. One takes their own tylenol at night sometimes before bed. Technically, I know that this is against regulation, however if staff do not give PRN's at night then the resident should be able to have prn, esp [sic] nitro or something for emergency purposes. Can we talk about this?" The consultant's response, identified in the email	01810			

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01810	Continued From page 91 by a different color text indicated, "Yes, you can determine during the medication assessment whether or not a resident is independent with all or some of their medications. For instance, you can say that a resident may keep eye drops or Tylenol at bedside as they are competent to self-administer these." The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated, "Procedure: 5. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use. 6. Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. 10. Over the counter medications will be kept in the original labeled containers and may be retained in general stock supply." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded prescription for	01820			

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01820	Continued From page 92 medications and obtained, and prescriptions were renewed at least every 12 months for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted June 7, 2024, to receive assisted living services. R1's diagnoses included hemiplegia, depression, and abnormal weight loss. R1's Service Plan signed April 25, 2025, indicated R1 received assistance with dressing, grooming, oral care, toileting including catheter care, transfers with mechanical full body lift, meals, medication administration, monthly blood pressure, and homemaking. On August 13, 2025, at 9:34 a.m., the surveyor observed R1's gluteal area and observed intact skin with a reddened area to the coccyx region. Unlicensed personnel (ULP)-B cleaned the area with wound cleanser, applied MediHoney gel to the reddened area on the coccyx and covered the area with an adhesive dressing. ULP-B stated "they do this for the resident every day" however did not know the frequency for each day. ULP-B stated they were unsure of where the frequency	01820			

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01820	Continued From page 93 was documented. On August 13, 2025, at 9:58 a.m., ULP-M stated they did not provide wound care for R1. ULP-M stated they placed a padded dressing to the reddened area of R1's skin for protection. On August 13, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-C stated they were not aware of a dressing or wound care for R1. On August 15, 2025, at 9:09 a.m., R1's primary care physician office's clinical assistant (CA)-O stated they had no record of R1 having a coccyx wound nor did they have record of writing a wound treatment order. The manufacturer's instructions for MediHoney dated 2025 indicated MediHoney gel was to be used for lightly to moderately exudating wounds that were hard to dress. In addition, during initial use of the product there was risk of maceration if the excess moisture was not managed appropriately and "protect the peri-wound skin by applying a skin barrier protectant to the surrounding skin." On August 15, 2025, at 11:03 a.m., CNS-C stated the licensee had a box of wound care supplies kept in the office. CNS-C stated the staff probably got the supplies from the wound care box. R2 R2 was admitted to the licensee on November 14, 2024. R2's diagnoses included type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavioral disturbance, altered mental status, and adult failure to thrive.	01820			

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01820	Continued From page 94 R2's Service Plan dated November 15, 2024, indicated R2 required total assistance with feeding via gastrostomy (G)-tube, medication administration via G-tube, grooming, dressing, toileting, assistance with meals, and two-person assist for transfers. On August 13, 2024, at 1:32 p.m., the surveyor observed an eight-ounce flow / 237 milliliter (ml) carton of Jevity 1.5 cal in R2's room. R2's signed provider order dated December 3, 2024, indicated R2 was to receive 720 ml of water total daily with 120 ml of water being given every 4 hours and 770 ml total daily of Jevity 1.5 calories (cal) at 55 ml per hour from 8:00 p.m. to 10:00 a.m. R2's record titled Changing Brief, G-Tube Feeding, Water Flushing, & ROM (Reposition) dated July 21 through August 13 (no year listed) indicated R2 received a total of 750 ml of water per day via G-tube and R2 received two packs of formula at 8:30 p.m., and one pack of formula was added to the tube feeding bag at 12:30 a.m., daily. The documented amounts indicated the licensee was providing R2 with 30 ml more than what was prescribed of water daily and the licensee was providing R2 with 59 ml less of formula than the prescriber's order daily. R2's eVital document dated November 15, 2024, through May 2, 2025, indicated R2 weighed 159 pounds (lbs) on November 15, 2024. There were no other weights recorded. On August 14, 2025, at 2:24 p.m., the surveyor asked the licensee to weigh R2 as R2's record at the facility contained no additional weights. R2's	01820			

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01820	Continued From page 95 weight was taken by ULP-B and ULP-M and R2 weighed 146.5 lbs, which indicated R2 had a weight loss of 12.5 lbs. On August 14, 2025, at 2:40 p.m., licensed assisted living director (LALD)-D stated R2's son wanted to decrease the amount of feeding R2 was receiving. LALD-D was unable to produce a physician order to decrease the amount of feeding. On August 15, 2025, at 12:04 p.m., during a phone interview with LALD-D and ULP/manager (M)-H, LALD-D stated R2's son requested a decrease in the tube feeding a "couple" months ago because he was worried that R2 gained too much weight after they started the tube feeding. LALD-D stated they needed a doctor's order to reduce the formula amount. LALD-D stated they believed the doctor decreased the amount from 3.5 "pack" to 3 packs per day. LALD-D stated they were unable to locate the prescriber's order. LALD-D provided the surveyor with a Clinic Referral dated December 3, 2024. The document indicated the licensee asked for a reduction in tube feeding formula to the prescriber. The document contained three signed written orders from the visit dated December 3, 2024, none were related to the tube feeding amount. The document did not indicate the prescriber agreed to decrease the tube feeding formula nor was a new order written related to the tube feeding formula. On August 15, 2025, at 2:23 p.m., the surveyor spoke, via phone, with dietitian at Fairview Infusion (DFV)-P regarding R2's tube feeding orders. DFV-P stated their office coordinator did get a call today (during the survey) from LALD-D who requested clarification and documentation of	01820			

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01820	Continued From page 96 R2's current tube feeding orders. DFV-P verbalized she also sent the order over to the licensee a couple of months ago because they couldn't find the order. DFV-P verbalized she had previously asked the facility if they could get a weight on R2 and the facility staff told her they had no way of weighing the resident. DFV-P or the coordinator were not updated on the weight loss identified yesterday by the facility. DFV-P stated she connects with the facility every two to three months. DFV-P stated R2 began tube feedings in 2023. As of November 2024, DFV-P stated resident was ordered Jevity 1.5, (therapeutic nutrition) 55 ml/hr (660 ml) for 12 hours, then in February 2025, the order was again reclarified based on the cartons to be used and remained very close to the same dose of Jevity 1.5, 60 ml/hr (705 ml) for 11.75 to 12 hours." Lastly, DFV-P verbalized now that she hears of R2's weight loss she would follow up to see if any recommended changes would be warranted. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew complete	01830			

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01830	Continued From page 97 prescriptions at least every 12 months for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted June 7, 2024, and had diagnoses including left-sided hemiplegia (muscle weakness or partial paralysis) post cerebral vascular accident (a stroke), type two diabetes, and major depressive disorder. On August 13, 2025, at 8:55 a.m., to 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-F assist R1 with personal cares and transfer R1 from her wheelchair to a shower chair. R1's Service Plan dated April 25, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, dressing, grooming, transfers, behavior management, catheter care, and medication administration. R1's medication administration record (MAR) dated August 1, 2025, through August 13, 2025, indicated R1 was scheduled to take the following medications: -acetaminophen (for pain) 650 milligrams (mg), one tablet, two times daily; -aspirin (for pain) 325 mg, one tablet, once daily;	01830			

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01830	Continued From page 98 -atorvastatin (for high cholesterol) 40 mg, one tablet, once daily at bedtime; -ipratropium-albuterol (for difficult breathing) 20-100 micrograms (mcg), inhale one puff, four times daily; -losartan (for high blood pressure) 25 mg, one tablet, once daily; -melatonin (for sleep) 3 mg, one tablet, once daily at bedtime; -MiraLAX powder (for constipation) 3350 national formulary/17 grams (gm), mix 17 gm with drink, once daily; -Myrbetriq (for overactive bladder) extended release (ER) 50 mg, one tablet, once daily; -olanzapine (for agitation/anxiety) 2.5 mg, one tablet, once daily; -pantoprazole (to decrease stomach acid) 40 mg, one tablet, once daily; -Refresh P.M. (nighttime) ointment (for dry eyes), apply to each lower eyelid, once daily at bedtime; -Systane Ultra (for dry eyes), instill one drop in each eye, three times daily; -trazadone (for sleep) 50 mg, one half tablet (25 mg), once daily at bedtime; and -vitamin D3 (a supplement) 25 mcg, one tablet, once daily. R1's medical record included signed provider orders dated July 23, 2025, but lacked the required prescription information of frequency for: -sennosides (for constipation) 8.6 mg tablet; -polyethylene glycol 3350 17 gram/dose oral powder; -bisacodyl (for constipation) 10 mg rectal suppository; -benzonatate (for cough) 100 mg capsule; -antacid extra strength (to decrease stomach acid) 750 mg chewable tablet; -arthritis pain relief ER 650 mg tablet; -vitamin D3 25 mcg (1,000 unit) tablet;	01830			

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01830	Continued From page 99 -trazadone 50 mg tablet; -Systane Ultra 0.4 %-0.3 % eye drops; -Refresh P.M. 57.3 %-42.5 % eye ointment; -pantoprazole 40 mg tablet, delayed release; -olanzapine 2.5 mg tablet; -Myrbetriq 50 mg tablet, extended release; -MiraLAX 17 gram/dose oral powder; -melatonin 3 mg tablet; -losartan 25 mg tablet; -fish oil (a supplement) 1,000 mg (120 mg-180 mg) capsule; -Combivent Respimat (for difficult breathing) 20 mcg-100 mcg/actuation solution for inhalation; -atorvastatin 40 mg tablet; -aspirin 325 mg tablet; and -acetaminophen 650 mg tablet. R1's medical record included signed provider orders dated July 23, 2025, but lacked the required prescription information of dosage and frequency for: -multivitamin with minerals (a supplement) tablet; and -vitamin B (a supplement) complex tablet. R1's medical record included a Medication and Treatment Orders - Assisted Living document signed June 17, 2024, which included the required prescription information of medication name, dosage, frequency, and directions for use. The document was dated over 12 months from the date of survey. On August 14, 2025, at 10:52 a.m., clinical nurse supervisor (CNS)-C stated she began employment with the licensee only a month ago and did not notice R1's signed medication orders were missing frequencies and some dosages of the scheduled medications. CNS-C stated the only complete prescription orders for R1 were	01830			

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01830	Continued From page 100 dated over a year ago. CNS-C stated she planned to follow up with R1's provider to obtain clarification of all R1's medication and treatment orders. The licensee's Prescriber's Order policy dated, August 1, 2021, included, "PROCEDURE: 1. Written orders from an authorized prescriber will be obtained for all medications* and treatments with which the assisted living facility assists residents, including over the counter medications. 2. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. 3. Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by home care staff. 4. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the facility will date the order when received from the prescriber. 5. Medication orders will include the name of the medication, dosage, and directions for use. 6. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. 7. Medication and treatment orders will be renewed at least every year or when changes occur." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			

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01870	Continued From page 101	01870			
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were included in the assessment for medication management or documented in the resident record for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 11, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated all residents at the facility received assistance with cares and medication administration. R3 was admitted to the licensee on July 8, 2024. R3's diagnoses included hypertension, carcinoma (bladder), orthostatic hypotension, insomnia,	01870			

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01870	Continued From page 102 syncope, gastric esophageal reflex disease, and low backpain. R3's Service Plan dated April 25, 2025, indicated R3 received assistance with activities, mobility, dressing, grooming, toileting, assistance with meals, medication administration, catheter care, meals, and housekeeping. R3's Medication Assessment form dated July 23, 2025, indicated the following: - R3 required staff assistance with reminders for when medications are due and required staff assistance with medication usage. No supplements or as needed (PRN) medications should be stored in R3's room with exception of Nitro sublingual (SL); - R3 required staff assistance with eye drop administration; - R3 needed assistance with reading medication name and dosage; - R3 needed assistance with what each medication was for; and - Staff will continue to provide assistance with all medication needs and administration. R3's Medication Administration Record (MAR) dated from August 1, 2025, to August 31, 2025, included the following: - nitroglycerin (Nitrostat) 0.4 milligram (mg), place one tablet under the tongue every five minutes as needed for chest pain; - acetaminophen (extra strength) 500 mg, take one tablet by mouth every six hours PRN; - cetirizine 10 mg, 1 tablet daily as needed; - aspirin chewable 81mg, take one tablet daily; and - Systane (artificial tears) 0.4% - 0.3%, place one to two drops into both eyes 4 times daily PRN for dry eyes.	01870			

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01870	Continued From page 103 On August 14, 2025, at 11:54 a.m., the surveyor observed the following medications in R3's room: - aspirin 81 mg enteric coated tablets; - allergy relief cetirizine 10mg; - acetaminophen 500 mg; - lubricating eye drop; - Centrum silver women 50+ multivitamin; - fish oil 1400 mg; - Seirogan herbal dietary supplement; and - Three unknown pills in a CVS pharmacy pill bottle. R3's medication management record including service plan, MAR, and medication assessment did not include the following over the counter supplements: - centrum silver women 50+ multivitamin; - fish oil 1400 mg; and - Seirogan herbal dietary supplement. On August 15, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-C stated they did not know R3 had the above-mentioned medications in their room except for Tylenol. On August 15, 2025, at 1:02 p.m., CNS-C stated none of the residents were assessed and deemed competent to administer their own medication. On August 15, 2025, at 2:03 p.m., LALD-D stated, they knew R3 had Tylenol and vitamins in their room. LALD-D stated R3's family member who lives out of state sends the medication for R3 and we just deliver it to R3. R3 is cognitively ok to self-administer. LALD-D stated the licensee staff did not administer vitamins and stated the licensee staff only administered R3's medications that are prescribed by the doctor.	01870			

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01870	Continued From page 104 The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated, "Procedure: 5. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use. 6. Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. 10. Over the counter medications will be kept in the original labeled containers and may be retained in general stock supply." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870			
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950			

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01950	Continued From page 105 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee did not train the proper methods for each resident (R2) receiving treatment of therapy services prior to delegating nursing tasks of prescribed treatments, nor did the unlicensed personnel (ULP) demonstrate to the registered nurse (RN), the ability to competently follow the procedure for four of four employees (ULP-A, ULP-B, ULP-F, ULP-K). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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: R2 was admitted to the licensee on November 14, 2024. R2's diagnoses included type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavioral disturbance, altered mental status, and adult failure to thrive. R2's Service Plan dated November 15, 2024, indicated R2 required total assistance with feeding via gastrostomy (G)-tube, medication administration via G-tube, grooming, dressing, toileting, assistance with meals, and two-person assist for transfers.	01950			

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01950	Continued From page 106 On August 13, 2024, at 1:32 p.m., the surveyor observed an eight-ounce flow / 237 milliliter (ml) carton of Jevity 1.5 cal in R2's room. R2's signed provider order dated December 3, 2024, indicated R2 was to receive 720 ml of water total daily with 120 ml of water being given every 4 hours and 770 ml total daily of Jevity 1.5 calories (cal) at 55 ml per hour from 8:00 p.m. to 10:00 a.m. On August 13, 2025, at 10:29 a.m., ULP-F stated they administered water through R2's feeding tube when they worked the overnight shift. ULP-F stated they were trained by other coworkers on how to give water through the feeding tube. ULP-F also stated after they gave the water to R2 they charted it on a paper chart and directed the surveyor to a clipboard with paper charting for feeding tube. On August 13, 2025, at 2:30 p.m., ULP-K stated they provided food to R2 through the feeding tube. ULP-K stated they give all three boxes of Jevity 1.5 calorie (cal) around 8:30 p.m., and then the tube feeding gets disconnected in the morning. ULP-A ULP-A was hired on June 17, 2025, to provide assisted living services. ULP-A's personnel file included a document titled Home Health Aide Competency Evaluation dated June 18, 2025, the document indicated ULP-A was competent to complete treatments as delegated and was signed by manager (M)-H. The document lacked which treatments were competency evaluated and lacked a competency	01950			

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01950	Continued From page 107 evaluation completed by a RN. ULP-B ULP-B was hired on April 1, 2025, to provide assisted living services. ULP-B's personnel file included a document titled Practical Skills Evaluation dated April 2, 2025, the document indicated ULP-B was competent to complete treatments as delegated and was signed by a ULP, M-H. The document lacked which treatments were competency evaluated and lacked a competency evaluation completed by a RN. ULP-F ULP-F was hired on September 23, 2024, to provide assisted living services. ULP-F's personnel file included a document titled Practical Skills Evaluation dated October 15, 2024, the document indicated ULP-F was competent to preform delegated treatments and was signed by a previous RN of the licensee. The document lacked which treatments were competency evaluated. ULP-K ULP-K was hired on April 1, 2024, to provide assisted living services. ULP-K's personnel file lacked training and competency evaluations related to treatments and therapies. On August 14, 2025, at 10:39 a.m., clinical nurse supervisor (CNS)-C stated it was not in their job description to be a CNS for the licensee. CNS-C stated they had one resident who had a tube feeding.	01950			

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01950	Continued From page 108 On August 14, 2025, at 10:54 a.m., CNS-C stated they were unable to find documentation of competency evaluations for employees for any treatments provided at the facility. CNS-C stated they believed ULP were trained by the hospice care nurse or a home care nurse. M-H walked into the room and stated ULP were "trained by Fairview" for tube feedings. On August 14, 2025, at 11:40 a.m., licensed assisted living director (LALD)-D stated, when R2 moved into the facility they called all employees into the facility and held an in-person training held by a nurse from a home care agency. LALD-D stated the home care nurse showed all employees each step on how to perform the tube feeding. LALD-D stated they did not document the tube feeding training however, they had each employee sign the care plan of the resident after they received the training. LALD-D stated, "whoever treat her with the tube formula they have signed her care plan." LALD-D stated for all other treatments the licensee provided services for, the licensee hired a nurse to come and train the employees on the specific treatment. LALD-D stated the nurse trained them and then watched them perform the treatments. LALD-D stated they did not have documentation for competency evaluations for employees for treatments performed in the facility. On August 14, 2025, at 12:46 p.m., ULP-K stated they were trained on tube feedings from a person who did not work for the licensee for 15 to 20 minutes, then the person had them demonstrate the skill back. ULP-K did not know the person's credentials or where they were from. On August 14, 2025, at 1:08 p.m., ULP-B stated	01950			

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01950	Continued From page 109 they were trained on how to do water flushes on a tube feeding and provide wound care by a certified nursing assistant (CNA). ULP-B was unable to name the CNA. On August 14, 2025, at 1:50 p.m., ULP-A stated they were trained to preform water flushes on a tube feeding by a coworker (ULP) and the housing supervisor. ULP-A stated neither of the employees was a nurse. On August 15, 2025, at 10:48 a.m., ULP-F stated they were trained on tube feedings by M-H. ULP-F stated they provided R2 with water via G-tube. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated if a RN or licensed professional delegates treatment or therapies, the professional would monitor and evaluate its effectiveness on a regular basis specified on the service plan. The licensee's Delegation of Assisted Living Tasks dated August 1, 2021, indicated the RN or licensed health professional was responsible for appropriately delegating tasks to staff who were competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The RN or licensed health professional would have access to the employee's personnel files or other reports to determine level of competence prior to delegation of any task so that up-to-date information about current available staff and their competency was available to have sufficient information to determine the appropriateness of delegating tasks to meet the resident's needs and preferences. In addition, a ULP who provided	01950			

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01950	Continued From page 110 delegated nursing services were orientated by a RN or licensed health professional prior to initiation of the service. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950			
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were documented accurately in the medical record for one of one resident (R2) with tube feeding. 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	01960			

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01960	Continued From page 111 a large portion or all of the residents). The findings include: R2 was admitted to the licensee on November 14, 2024. R2's diagnoses included type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavioral disturbance, altered mental status, and adult failure to thrive. R2's Service Plan dated November 15, 2024, indicated R2 required total assistance with feeding via gastrostomy (G)-tube, medication administration via G-tube, grooming, dressing, toileting, assistance with meals, and two-person assist for transfers. On August 13, 2024, at 1:32 p.m., the surveyor observed an eight-ounce flow / 237 milliliter (ml) carton of Jevity 1.5 calories (cal) in R2's room. R2's signed provider order dated December 3, 2024, indicated R2 was to receive 720 ml of water total daily with 120 ml of water being given every 4 hours and 770 ml total daily of Jevity 1.5 cal at 55 ml per hour from 8:00 p.m. to 10:00 a.m. R2's Treatment Plan dated November 15, 2024, indicated enteral feeding 8:00 p.m. to 10:00 a.m., daily. The treatment plan did not specify the kind of assistance provided to R2 or what kind of food to administer, and the amount food to be administered. R2's Care Plan Record dated from August 1, 2025, to August 31, 2025, indicated the following: - Staff to assist with tube feeding from 2000 (8:00 p.m.) to 1000 (10:00 a.m.) daily per order. (The	01960			

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01960	Continued From page 112 order did not specify the kind of assistance provided to R2 or what kind of food to administer, and the amount food to be administered.) - Staff to assist with G-Tube water flushes 125 mls every 4 hours (schedule in the room). R2's paper chart entitled Changing brief, G-tube feeding, Water flushing & ROM (Reposition) schedule dated August 13, [year was not indicated] indicated the following order for tube feeding: - at 8:30 a.m., remove an old bag; - at 8:30 p.m., pour two packs in a new bag; and - at 12:30 a.m., add one pack. On August 13, 2025, at 10:29 a.m., unlicensed personnel (ULP)-F stated they administered water through R2's feeding tube when they worked the overnight shift. ULP-F stated they were trained by other coworkers on how to give water through the feeding tube. ULP-F also stated after they gave the water to R2 they charted it on a paper chart and directed the surveyor to a clipboard with paper charting for feeding tube, mentioned above. On August 13, 2025, at 2:30 p.m., ULP-K stated they provided food to R2 through the feeding tube. ULP-K stated they give all three boxes of Jevity 1.5 calorie (cal) around 8:30 p.m., and then the tube feeding gets disconnected in the morning. On August 14, 2025, at approximately 3:05 p.m., ULP-J stated they flushed the tube feeding at 12:00 a.m., and at 4:00 a.m., with 125ml of water. ULP-J stated they did not administer food through the feeding tube; ULP-J stated ULPs who worked afternoon shifts administer food through the feeding tube.	01960			

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01960	Continued From page 113 R2 was receiving three packs of Jevity through feeding tube all at once per the ULP's interviews. The charting indicated R2 was receiving 2 packs of Jevity at 8:30 p.m., and 1 pack of Jevity at 12:30 a.m., the electronic medication administration record (eMAR) did not indicate the kind of feeding tube assistance provided to R2, what kind of food to administer, or the amount of food to be administered. On August 15, 2025, at 1:07 p.m., clinical nurse supervisor (CNS)-C stated the charting was not enough and it was not easy to track. CNS-C stated they had addressed the issue to the licensee many times and they had been told by the licensee that they had been doing this for the last 20 years and it had worked fine. The licensee's Treatment and Therapy Management policy dated August 1, 2021, read, "1. A Registered Nurse (RN) or other licensed professional will complete an assessment of all residents receiving treatment or therapy services prior to the initiation of those services. 2. The RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided c. Frequency d. Other pertinent information 3. If the RN or licensed professional delegates* treatments or therapies, the professional will monitor and evaluate its effectiveness on a regular basis as specified in the service plan. 4. The RN or licensed professional will provide education to the resident, the resident's	01960			

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01960	Continued From page 114 designated representative and/or the resident's legal representative regarding the treatment or therapy and may, as appropriate, instruct other team members, including paraprofessionals, to provide on-going teaching based on the written resident education instructions prepared by the RN or licensed professional. 5. The RN or licensed professional will, as appropriate, provide coordination of care related to the treatment or therapy activities with the following. a. Resident b. Resident's Representative(s) c. Prescriber d. Primary care provider e. Other health care providers 6. The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service 7. Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record.** 8. When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the resident's needs as documented in the care	01960			

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01960	Continued From page 115 plan or treatment plan or as ordered by the authorized prescriber." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02410			

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02410	Continued From page 116 review, the licensee failed to ensure privacy was maintained for three of six residents (R5, R7, R8) while receiving personal cares. In addition, the licensee failed to ensure information regarding the resident's service plan, case discussion, and treatments was kept confidential for all residents receiving assistance with toileting, meal delivery, transportation, shower, face wash, and oral care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: PERSONAL CARES On August 11, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated all residents at the facility received assistance with cares and medication administration. In addition, LALD-D stated they were familiar with the current minimum assisted living requirements. R5, R7, and R8, were admitted April 11, 2022, March 1, 2019, and April 11, 2022, respectively, and received services provided by the licensee's nurses and unlicensed personnel (ULP) employees. On August 13, 2025, at 9:50 a.m., ULP-B stated R5, R7, and R8 shared a bedroom. ULP-B stated she was not aware why the bedroom did not have privacy curtains to use while providing personal	02410			

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02410	Continued From page 117 cares. ULP-B stated R5, R7, and R8 received personal care services but all three of the residents were already up for the day and were sitting in the main living area. On August 13, 2025, at 9:58 a.m., the surveyor observed along with ULP-M a bedroom being shared by three residents (R5, R7, and R8) in the lower level of the facility. The back corner of the room had a bedside commode sitting next to a resident's bed. There was one additional bed which was not in use but was intended for a fourth resident in the room. When asked, ULP-M stated she was not sure why the room did not have privacy curtains to separate the bed areas for privacy of cares. ULP-M stated the other rooms had privacy curtains in use and was not sure how this room was missed. ULP-M stated yes, this could be a privacy concern if personal cares or toileting assistance were provided to R5, R7, and R8 given there were no curtains separating the shared resident's bedroom. CHARTING POSTED IN COMMON AREA On August 15, 2025, at 12:20 p.m., the surveyor observed a bulletin board in the facility's main dining room on the main floor with the following resident information: - Resident Shower Schedule charting table, with resident's initials, shift/date and initials of employee's who performed the task; - August Transportation Schedule with date, resident's initials, transportation, appointment time, pick up time, return time and confirm; - Activities of Daily Living (ADLs) -AM Shift charting dated August 15, 2025, with the following information: 1. Before and after breakfast: " Face wash and oral care [charting table with resident's initial for those	02410			

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02410	Continued From page 118 receiving face wash and oral care service] " Deliver the meal and pick up the tray [charting table with resident's initial for those receiving meal deliver service] 2. For [R2's] initial " Remove the feeding tube bag, oral care with sponge, face wash 3. Toileting every 2-3 hours [charting table with resident's initial for those receiving toileting service]. On August 15, 2025, at approximately 1:05 p.m., clinical nurse supervisor (CNS)-C stated posting the above-mentioned information on the board in common area was probably a health insurance portability and accountability act (HIPAA) violation. On August 15, 2025, at 2:12 p.m., licensed assisted living director (LALD)-D stated, they did not see a privacy issue with posting the above-mentioned resident information in the common area as the charting only contained resident's initials. On August 12, 2025, at 12:48 p.m., the surveyor observed a photo frame posted on the outside of each resident's room with the resident's full name. The licensee's master Assisted Living Contract included, "Accommodations: [Licensee] will provide the resident the following Accommodations which are included in the basic daily fee: 1. Use of the private or shared room and the personal property of [Licensee] located in the room, including furniture (bed, dresser and chair) and linens, a closet and window coverings. You may provide any furnishings and decorations for	02410			

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02410	Continued From page 119 your private living area, except that content on display may not be obscene or prejudicial. If you prefer your own furniture, you are welcome to bring it. However, please be sure that it is in good repair. [Licensee] is committed to maintaining a safe, clean and attractive environment. Please talk with the Director if there are any repairs that are needed and support us in maintaining a safe environment by treating the furnishings and fixtures with care. The fire department discourages the use of extension cords." The Minnesota Bill of Rights for Assisted Living dated April 30, 2024, indicated, "10. Personal and treatment privacy. Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information was provided.	02410			

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02410	Continued From page 120	02410			
03090 SS=C	TIME PERIOD FOR CORRECTION: Seven (7) days 144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that will cause only 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: On August 11, 2025, at 11:30 a.m., during a facility tour, the surveyor did not observe a posted electronic monitoring notice throughout the facility.	03090			

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03090	Continued From page 121 On August 11, 2025, at 11:36 a.m., licensed assisted living director (LALD)-D stated they were not aware of the requirement to post an electronic monitoring notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Metro District Office
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625 Robert St N, PO BOX 64975
St Paul, MN 55164
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Food & Beverage Inspection Report

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Establishment Info	License Info	Inspection Info
GOLDEN NEST LLC 1918 19TH AVENUE NE Minneapolis, MN 55418 Hennepin County Parcel: Phone:	License: HFID 27473 Risk: License: Expires on: CFPM: Kyung S. Min CFPM #: FM123144; Exp: 5/22/2027	Report Number: F1004251116 Inspection Type: Full - Single Date: 8/11/2025 Time: 11:30:00 AM Duration: minutes Announced Inspection: Total Priority 1 Orders: 1 <u>Total Priority 2 Orders: 1</u> <u>Total Priority 3 Orders: 2</u> <u>Delivery:</u>

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

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 at the specific request of the regulatory authority.

COMMENT: KITCHEN MANAGER STATED AN EMPLOYEE ILLNESS LOG IS NOT USED IN THE ESTABLISHMENT. ALL EMPLOYEE REPORTS OF VOMITING, DIARRHEA, OR OTHER SYMPTOMS ASSOCIATED WITH FOODBORNE ILLNESS, MUST BE RECORDED. *EMPLOYEE ILLNESS LOG PROVIDED WITH REPORT.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 4-100 Equipment Construction Materials

4-101.19 Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

COMMENT: 2-DOOR REFRIGERATOR AND FREEZER STILL HAVE THE PROTECTIVE SHIPPING PLASTIC FILM ON. REMOVE FILM.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.12 Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT: NO PAPER TOWELS STOCKED AT HANDWASHING SINK. PROVIDE AND MAINTAIN. *FOOD EMPLOYEE PROVIDED PAPER TOWELS DURING INSPECTION- ENSURE DISPENSER IS KEPT BY THE HANDWASHING SINK FOR USE.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A Priority Level: Priority 3 CFP#: 10

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

COMMENT: NO HANDWASHING SIGN/POSTER AT HANDWASHING SINK. PROVIDE AND MAINTAIN.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY DEE MOSISSA.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- SANITIZER USE AND TEST KITS
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES (SAME-DAY SERVICE)
- PEST CONTROL
- PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE KITCHEN MANAGER ON SITE AND WITH THE NURSE EVALUATOR, DEE.

*FLOORS ARE TILE, WALLS ARE TILE AND SMOOTH PAINTED DRYWALL, AND CEILING IS TILE. COUNTERTOPS ARE LAMINATE AND CABINETS ARE LAMINATE COVERED IN CONTACT PAPER WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1004251116 from 8/11/2025

Molly Dougherty

Kyungsin Min
Certified Food Protection Manager

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

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Establishment Info

GOLDEN NEST LLC

Minneapolis

County/Group: Hennepin County

Inspection Info

Report Number: F1004251116

Inspection Type: Full

Date: 8/11/2025

Time: 11:30:00 AM

Food Temperature: **Product/Item/Unit:** sprouts; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** soup; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** cabbage; **Temperature Process:** Cold-Holding

Location: Refrigerator (outside of kitchen) at 40 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

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Establishment Info	Inspection Info
GOLDEN NEST LLC	Report Number: F1004251116
Minneapolis	Inspection Type: Full
County/Group: Hennepin County	Date: 8/11/2025
	Time: 11:30:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No