Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 16, 2023

Licensee
Golden Manor Of Detroit Lakes
1159 Garnet Boulevard
Detroit Lakes, MN 56501

RE: Project Number(s) SL24138015

On August 10, 2023, 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 June 14, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 14, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on June 14, 2023, found not corrected at the time of the August 10, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = $500.00

The details of the violations noted at the time of this follow-up survey completed on August 10, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24138	A. BUILDING: ____ B. WING ____	R 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR OF DETROIT LAKES	1159 GARNET BOULEVARD DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL24138015-1 On August 10, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 14, 2023. At the time of the survey, there were 20 residents: all of whom were receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	{0 470}		

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{0 470}	Continued From page 1 (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: No further action required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 10, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	{0 810}		

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{0 810}	Continued From page 3 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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: No further action required.	{0 810}		
{01290} SS=D	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 an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	{01290}		

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{01290}	Continued From page 4 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}		
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action required.	{01750}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	{01760}		

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{01760}	Continued From page 5 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01880} SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{02070} SS=F	144G.81 Subd. 4 Awake staff requirement	{02070}		

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{02070}	Continued From page 6 An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: No further action required.	{02070}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action required.	{02310}		

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164
218-332-5150

Type: Full
Date: *08/10/23*
Time: 17:05:39
Report: 1042231037

Food and Beverage Establishment Inspection Report

Location:
Golden Manor of Detroit Lakes
1165 Garnet Boulevard
Detroit Lakes, MN56501
Becker County, 03

Establishment Info:
ID #: 0017518
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Golden Manor Corporation

Phone #: 2188443300
ID #: 16453

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

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Facilities still serving eggs which are undercooked/not fully cooked including fried eggs, over-easy eggs, and poached eggs. Staff believe eggs are pasteurized, yet order was made to refrain from this on 6/12/23.

Comply By: 08/10/23

4-500 Equipment Maintenance and Operation

4-501.112A ***** Priority 2 *****

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

Dishwashers determined to not reach minimum temperature of 165 degrees F, BEING REPLACED/IN PROCESS OF REPLACEMENT.

Comply By: 08/10/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

PER ORDER ON 6/12/2023: Facility is still holding cut fruits/vegetables for longer than same-day service.
CORRECTED ON SITE: Inspector watched staff dispose of celery sticks being kept in plastic bin/plastic bag and submerged in water.

Food and Beverage Establishment Inspection Report

Comply By: 08/10/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39.6 Degrees Fahrenheit - Location: Shredded Cheese.
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36.2 Degrees Fahrenheit - Location: Unopened Packaged Salad for Side
Violation Issued: No

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

REMEMBER: Storage of fruits/vegetables in water can serve as a potential breeding ground for bacteria which can be particularly harmful to individuals over the age of 65 and those with acute and/or chronic medical conditions.

For the future: integrate inspection reports into planning for daily activities of staff such as ensuring food is properly disposed of after same-day service. If in doubt, toss it out.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

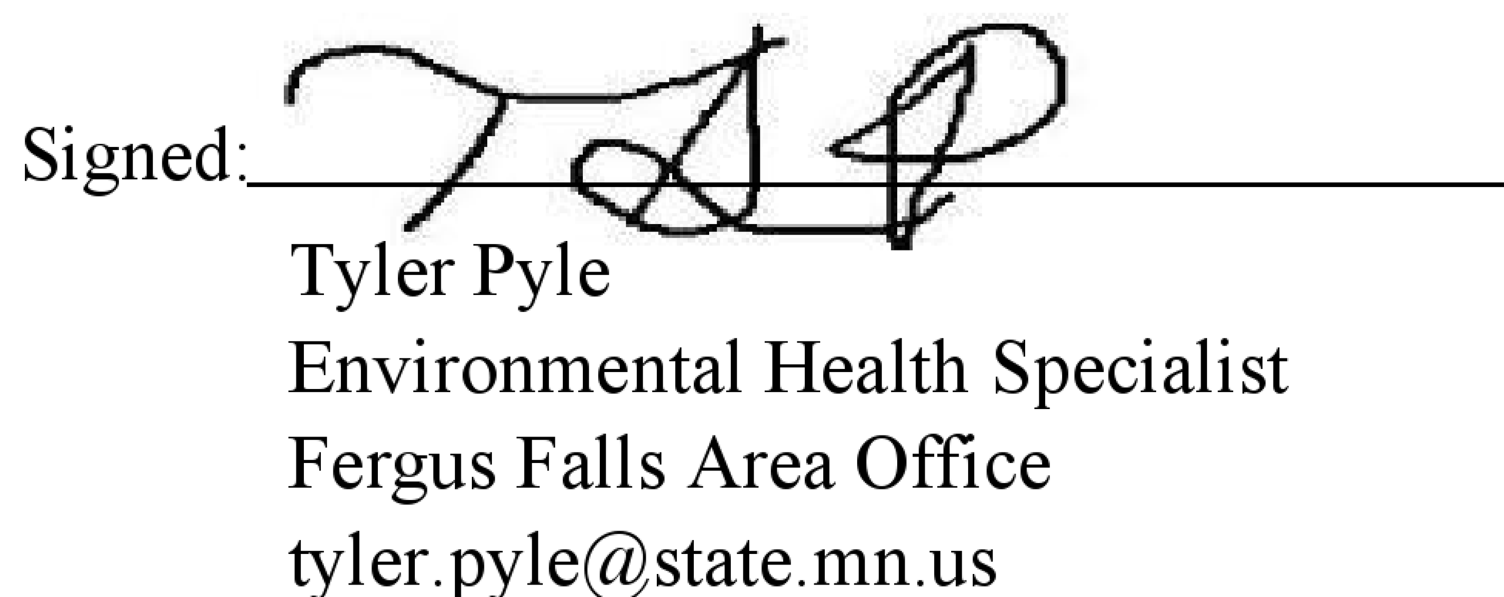
I acknowledge receipt of the MN Department of Health inspection report number 1042231037 of 08/10/23.

Certified Food Protection Manager: Michelle Tollefson

Certification Number: 110526 Expires: 04/13/25

Inspection report reviewed with person in charge and emailed.

Signed:________________
Establishment Representative

Signed: 
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us

Report #: 1042231037

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164

No. of RF/PHI Categories Out	2	Date	08/10/23
No. of Repeat RF/PHI Categories Out	0	Time In	17:05:39
Legal Authority MN Rules Chapter 4626		Time Out	

Golden Manor of Detroit Lakes	Address 1165 Garnet Boulevard	City/State Detroit Lakes, MN	Zip Code 56501	Telephone 2188443300
License/Permit # 0017518	Permit Holder Golden Manor Corporation	Purpose of Inspection Full	Est Type	Risk Category L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

#	Compliance Status (circled)	Item	COS	R
		Surpervision		
1	IN	PIC knowledgeable; duties & oversight		
2	IN	Certified food protection manager, duties		
		Employee Health		
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
		Good Hygenic Practices		
6	N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
		Preventing Contamination by Hands		
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	Adequate handwashing sinks supplied/accessible		
		Approved Source		
11	IN	Food obtained from approved source		
12	IN	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
		Protection from Contamination		
15	IN	Food separated and protected		
16	OUT	Food contact surfaces: cleaned & sanitized		
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
		Time/Temperature Control for Safety		
18	N/O	Proper cooking time & temperature		
19	N/O	Proper reheating procedures for hot holding		
20	IN	Proper cooling time & temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/O	Time as a public health control: procedures & records		
		Consumer Advisory		
25	N/A	Consumer advisory provided for raw/undercooked food		
		Highly Susceptible Populations		
26	OUT	Pasteurized foods used; prohibited foods not offered		
		Food and Color Additives and Toxic Substances		
27	IN	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
		Conformance with Approved Procedures		
29	N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

#	Status	Item	COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/10/23

Inspector (Signature)

Electronically Delivered

June 29, 2023

Licensee
Golden Manor Of Detroit Lakes
1159 Garnet Boulevard
Detroit Lakes, MN 56501

RE: Project Number(s) SL24138015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL24138015 On June 12, 2023, through June 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 20 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on June 13, 2023, issued for SL24138015, tag identification 2070. On June 13, 2023, at 3:39 p.m., the immediacy of correction order 2070 was removed, however, non-compliance remained at a scope and level of F.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24138	A. BUILDING: ______ B. WING ______	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR OF DETROIT LAKES	1159 GARNET BOULEVARD DETROIT LAKES, MN 56501

(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
0 470	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 interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. 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	0 470		

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0 470	Continued From page 2	0 470		

Continued From page 2

resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 22 and had a current census of 20 residents.

During the entrance conference on June 12, 2023, at 9:56 a.m., CNS-B and licensed practical nurse (LPN)-A stated the licensee had a staffing plan developed by CNS-B and LPN-A and was reviewed at least every six months. The surveyor requested the staffing plan, which was later provided.

On June 13, 2023, at 12:26 p.m., the surveyor reviewed the staffing plan with licensed assisted living director (LALD)-I. LALD-I stated the staffing plan had not been signed by CNS-B nor reviewed every six months as required.

On June 14, 2023, at 10:15 a.m., CNS-B stated the staffing plan had not been reviewed every six months nor signed by CNS-B.

The licensee's Staffing Plan Template policy dated August 1, 2021, indicated the staffing plan must be reviewed by the CNS bi-annually or as resident acuity requires.

No further information was provided.

TIME PERIOD OF CORRECTION: Twenty-One (21) days

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0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

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

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0 810	Continued From page 5 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). Findings include: A record review and interview were conducted on June 13, 2023, at approximately 11:45 a.m. with Maintenance Director (MD)-E and Management Administrator (MA)-H, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and	0 810		

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0 810	Continued From page 6 unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, MD-E and MA-H, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	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 an employee 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	01290		

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01290	Continued From page 7 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 current employee records contained all the required content to include a background study clearance letter with the correct affiliation for the assisted living facility for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-D was hired on February 20, 2023, to provide direct assisted living services. On June 13, 2023, at 8:50 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R6. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license. On June 14, 2023, at 11:34 a.m., clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-A stated ULP-D was currently employed by the facility and the affiliation for the employee's background study was for a sister facility site.	01290		

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01290	Continued From page 8 The licensee's Background Checks policy dated August 1, 2021, indicated once an approved background study has been received, a copy of completed background studies shall be kept in a separate consolidated locked file. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of one resident (R2) who received medication management. 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	01750		

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01750	Continued From page 9 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 12, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included end stage renal disease, asthma and diabetes. R2's service plan dated March 31, 2023, indicated R2 received medication administration seven times daily. R2's prescriber orders dated March 21, 2023, included an order for Breo Ellipta 100-25 micrograms (mcg) (used to decrease lung inflammation) one puff inhaled daily. R2's June 2023 electronic medication administration record indicated Breo Ellipta 100-25 mcg inhale one puff by mouth once daily, however, did not include instruction to rinse resident's mouth after use. On June 13, 2023, at 7:57 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a medication pass for R2, which included administration of the Breo Ellipta 100-25 mcg inhaler. ULP-C activated the Breo Ellipta inhaler and handed it to R2 for self-administration. R2 returned the Breo Ellipta inhaler back to ULP-C. ULP-C did not offer R2 water to rinse out mouth	01750		

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01750	Continued From page 10 after the inhaler administration. On June 13, 2023, at 8:24 a.m., ULP-C stated water is not offered to rinse out the resident's mouth for any resident that uses an inhaler. On June 14, 2023, at 10:19 a.m., CNS-B stated residents should be offered water to rinse their mouth after inhaler administration. CNS-B further stated residents will refuse to rinse mouth as they have never rinsed their mouth after use, however ULPs should still be offering the water for a mouth rinse. The manufacturer's instructions for use of Breo Ellipta inhaler dated January 2019, indicated to rinse mouth with water and spit the water out. Do not swallow the water. The licensee's Inhaler policy dated August 1, 2021, indicated to provide the resident the opportunity to rinse out their mouth after administration. The licensee's Discus Inhaler-Administration policy dated August 1, 2021, indicated to instruct resident to rinse mouth with water and spit the water out when done. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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01760	Continued From page 11	01760		

resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were administered per manufacturer's instructions and the licensee's policies for one of one resident (R2) observed during medication administration.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on June 12, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility.

R2's diagnoses included end stage renal disease,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 12 asthma and diabetes. R2's service plan dated March 31, 2023, indicated R2 received medication administration seven times daily. R2's prescriber orders dated March 21, 2023, included an order for Breo Ellipta 100-25 micrograms (mcg) (used to decrease lung inflammation) one puff inhaled daily. R2's June 2023 electronic medication administration record indicated Breo Ellipta 100-25 mcg inhale one puff by mouth once daily, however, did not include instruction to rinse resident's mouth after use. On June 13, 2023, at 7:57 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a medication pass for R2, which included administration of the Breo Ellipta 100-25 mcg inhaler. ULP-C activated the Breo Ellipta inhaler and handed it to R2 for self-administration. R2 returned the Breo Ellipta inhaler back to ULP-C. ULP-C did not offer R2 water to rinse out mouth after the inhaler administration. On June 13, 2023, at 8:24 a.m., ULP-C stated water is not offered to rinse out the resident's mouth for any resident that uses an inhaler. On June 13, 2023, at 9:00 a.m., ULP-D stated normally residents take a drink with their oral medications after the inhaler medications have been administered. On June 14, 2023, at 10:19 a.m., CNS-B stated residents should be offered water to rinse their mouth after inhaler administration. CNS-B further stated residents will refuse to rinse mouth as they	01760		

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	24138	A. BUILDING: ____ B. WING ____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR OF DETROIT LAKES	1159 GARNET BOULEVARD DETROIT LAKES, MN 56501

(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
01760	Continued From page 13 have never rinsed their mouth after use, however ULPs should still be offering the water for a mouth rinse. The manufacturer's instructions for use of Breo Ellipta inhaler dated January 2019, indicated to rinse mouth with water and spit the water out. Do not swallow the water. The licensee's Inhaler policy dated August 1, 2021, indicated to provide the resident the opportunity to rinse out their mouth after administration. The licensee's Discus Inhaler-Administration policy dated August 1, 2021, indicated to instruct resident to rinse mouth with water and spit the water out when done. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two medication refrigerators maintained an acceptable temperature and medications were stored according to manufacturer's	01880		

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	24138	A. BUILDING: ___ B. WING ___	06/14/2023

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01880	Continued From page 14	01880		

Continued From page 14

recommended temperature.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on June 12, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility.

On June 12, 2023, at 10:33 a.m., the medication refrigerator on the unsecured unit was reviewed with unlicensed personnel (ULP)-C. ULP-C stated the current temperature of the refrigerator was 50 degrees Fahrenheit (F) and the refrigerator temperature was checked every night by ULPs.

The refrigerator included the following medications:
-five unopened Humalog 100 units/milliliters (mL) insulin pens for R3;
-five unopened Lantus 100 units/mL insulin pens for R3;
-five unopened Novolog 100 units/mL insulin pens for R4; and
-four unopened Lantus 100 units/mL insulin pens for R5.

The licensee's Chore Recap by Specific Chore

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	24138	A. BUILDING: ______ B. WING ______	06/14/2023

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01880	Continued From page 15 dated May 1, 2023, through June 12, 2023, included medication refrigeration temperatures documented every night by ULPs. The instructions listed, "Medication fridge-**If temperature is outside of appropriate range, please identify action taken** Appropriate temperature range: Medication Refrigerator: 36 degrees F to 46 degrees F- Target is 40 degrees F [sic]." The following entries were documented outside of the appropriate temperature range per the licensee's instructions: -May 6, 2023, at 11:48 p.m., indicated 21 degrees F; -May 12, 2023, at 11:17 p.m., indicated 30 degrees F; -May 14, 2023, at 2:05 a.m., indicated "low doesn't state temperature, messaged maintenance director [sic]"; -May 16, 2023, at 11:41 p.m., indicated 34 degrees F; -May 18, 2023, at 11:41 p.m., indicated 32 degrees F; -May 20, 2023, at 11:36 p.m., indicated 32 degrees F, "defrosting now"; -May 22, 2023, at 12:08 a.m., indicated 34 degrees F; -May 23, 2023, at 11:38 p.m., indicated 30 degrees F; -May 29, 2023, at 12:05 a.m., indicated 30 degrees F; -June 6, 2023, at 1:04 a.m., indicated 52 degrees F; -June 7, 2023, at 11:35 p.m., indicated 50 degrees F; -June 8, 2023, at 12:27 a.m., indicated 48 degrees F; and -June 9, 2023, at 11:25 p.m., indicated 50 degrees F. On June 12, 2023, at 11:51 a.m., CNS-B stated	01880		

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01880	Continued From page 16 the expected temperature range for the medication refrigerator was 36 degrees F to 46 degrees F and 50 degrees F would be out of the range for the insulin pens to be stored according to manufacturer's instructions. The manufacturer's instructions for Humalog insulin pens dated November 2019, indicated before opening store the insulin pens in the refrigeration (36-46 degrees F). Do not allow the Humalog to freeze. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog dated March 2021, indicated before opening store the pen in the refrigerator (36-46 degrees F). Do not allow Novolog to freeze. The licensee's Storage of Medication policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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01890	Continued From page 17	01890		

label with legible information including the expiration or beyond-use date of a time-dated drug.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for one of one resident (R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

During the entrance conference on June 12, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility.

On June 12, 2023, at 10:23 a.m., the medication cart on the unsecured unit was reviewed with unlicensed personnel (ULP)-C.

R2's Levemir 100 units/milliliters (mL) insulin pen (a multiple dose pen shaped injector device for insulin administration) did not include the date the pen was opened or the date the pen would expire.

On June 12, 2023, at 10:23 a.m., ULP-C stated

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01890	Continued From page 18	01890		

ULP-C was not sure when the insulin pen was opened. ULP-C further stated the insulin pen should be dated when opened and when the pen would expire.

On June 12, 2023, at 11:50 a.m., CNS-B stated insulin pens should be dated when opened and should refer to the pharmacy instructions to label the date the pen would expire.

The manufacturer's instructions for Levemir insulin pens dated January 2019, directed to discard the pen 42 days after it had been opened, even if it still had insulin left in it.

The licensee's Storage of Medications policy dated August 1, 2021, indicated medications need to be labeled and dated with the open date, expiration date, if applicable upon opening the medication.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

02070 SS=F | 144G.81 Subd. 4 Awake staff requirement | 02070

An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).

This MN Requirement is not met as evidenced

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by:
Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in one of one secure (a unit requiring key code access to enter and exit) memory unit. This had the potential to affect all residents residing in the memory care unit.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

This practice resulted in an immediate order on June 13, 2023, at approximately 1:00 p.m.

The findings include:

The licensee held an Assisted Living with Dementia Care license with a capacity of 22 and had a current census of 20 residents (10 residents resided in the secured unit, 10 residents resided in the non-secured unit.)

During the entrance conference on June 12, 2023, at 9:57 a.m., clinical nurse supervisor (CNS)-B stated the facility's routine staffing schedule included three to four unlicensed personnel (ULP) on the day shift (7:00 a.m. to 3:00 p.m.); three to four ULP on the evening shift (3:00 p.m. to 11:00 p.m.); and two awake ULP on the night shift (11:00 p.m. to 7:00 a.m.; one ULP

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NAME OF PROVIDER OR SUPPLIER: **GOLDEN MANOR OF DETROIT LAKES**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1159 GARNET BOULEVARD DETROIT LAKES, MN 56501**

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02070	Continued From page 20	02070		

in the secured unit, one ULP in the non-secured unit).

On June 12, 2023, at 10:37 a.m., during a facility tour, licensed practical nurse (LPN)-A stated they have a secured memory care unit which has a key-pad access code to enter and exit the secured unit.

The physical layout of the facility included two separate buildings across the parking lot from each other, one building was a secured memory unit and the other building was an unsecured unit. There were no residents that required a two person transfer in the unsecured unit.

A review of the facility's time cards from April 23, 2023, until June 10, 2023, indicated only two ULPs worked the night shift from 11:00 p.m. to 7:00 a.m.

On June 13, 2023, at 6:34 a.m., ULP-F had worked in the unsecured unit overnight, and stated she worked part time on the night shift and worked the night shift on the unsecured unit. ULP-F stated if a fall occurred on unsecured assisted living unit, the ULP on the secured memory unit would leave the unit unattended to go assist and then return to the secured unit.

On June 13, 2023, at 6:49 a.m., ULP-G had worked in the secured unit overnight, and stated she worked full time on the night shift, which included rotating between the secured and unsecured units. ULP-G just completed working on the secured memory care unit. ULP-G stated if fall would occur in the unsecured unit, ULP-G would need to leave the secured unit unattended to go assist.

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Review of the licensee's Incident Summary-One Campus dated December 1, 2022, through June 12, 2023, indicated there were four falls during the hours of 11:00 p.m. and 7:00 a.m.

Review of R1's Fall- [resident's name] dated April 24, 2023, at 5:30 a.m., indicated R1 was transferring from toilet to walker when resident's feet started to slip, previous employed ULP gently lowered R1 to the floor. Previous ULP "and coworker (ULP from secured memory care unit) were able to get resident up and into a wheelchair."

On June 13, 2023, at 11:10 a.m., CNS-B stated on April 24, 2023, the ULP working the secured memory unit left the unit to assist the ULP working on the unsecured unit with R1's transfer. CNS-B stated if a fall occurs on the unsecured assisted living, ULPs were trained to call emergency medical services (EMS) to assist with a two person transfer after a resident fall.

On June 13, 2023, at 12:54 p.m., CNS-B stated during the time the ULP left the secured unit the residents would summon for help via emergency pull cords located in each resident room and the ULP would be able to answer any call that occurred when the ULP returned to the secured memory unit.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 20, 2021, indicated the number of direct care staff typically scheduled for the night shift was two. The facility was a secure unit or building for wandering or exit-seeking behavior. In addition, ULP were in the building and available to respond to resident requests 24/7.

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02070	Continued From page 22 The licensee's Staffing Plan Template dated August 1, 2021, indicated the plan was reviewed by CNS bi-annually or as resident acuity requires, however was not signed by any CNS or registered nurse. The Staffing Plan Template indicated there would be one ULP staffed in each building from 11:00 p.m. to 7:00 a.m. The licensee's Resident-Falls policy dated August 1, 2021, indicated all falls for residents over 150 pounds, would be assisted off of the floor with the assist of two staff and a mechanical lift. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on June 13, 2023, at 3:39 p.m., however, non-compliance remains at a scope and level of two, widespread (F).	02070		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who resided in the secured memory unit (a unit required to use a key code to enter and	02310		

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02310	Continued From page 23 exit) with regard to safely storing chemicals. This had the potential to affect all 10 residents in the secured unit, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living with dementia care license. On June 12, 2023, at 9:33 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided services to residents with dementia and other related disorders. On June 12, 2023, at 10:40 a.m., during the facility tour with licensed practical nurse (LPN)-A, the surveyor observed a ¾ bottle full of Simple Green All-Purpose Cleaner located on a shelf in the resident shared space in the secured memory unit. LPN-A stated all residents could have accessed the Simple Green All-Purpose Cleaner and it should have been kept in the locked laundry room. On June 12, 2023, at 11:52 a.m., CNS-B stated all chemicals should be stored in a locked laundry or maintenance room. The Simple Green All-Purpose Cleaner Safety Data Sheet dated February 1, 2021, indicated if	02310		

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02310	Continued From page 24 ingested may cause an upset stomach. The licensee's undated Laundry Room/Chemical Room policy indicated all chemicals must be secured by closed/lockable door to ensure they are safe from residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64495
St Paul, MN 55164-0495
651-201-4500

Type: Full
Date: *06/12/23*
Time: 11:28:48
Report: 1034231113

Food and Beverage Establishment Inspection Report

Location:
Golden Manor Of Detroit Lakes
1159 Garnet Boulevard
Detroit Lakes, MN56501
Becker County, 03

Establishment Info:
ID #: 0038669
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188846028
ID #:

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

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

ESTABLISHMENT WAS LETTING RESIDENTS HAVE NOT FULLY-COOKED EGGS INCLUDING FRIED EGGS. DISCONTINUE PRACTICE OR BUY PASTEURIZED EGGS.

Comply By: 06/12/23

4-500 Equipment Maintenance and Operation

4-501.112A ***** Priority 2 *****

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

DISHWASHERS CAN ONLY REACH A TEMP OF 156 DEGREES F ACCORDING TO SPEC SHEETS. HOT WATER MUST REACH AT LEAST 165 DEGREES F ON SANITIZING RINSE.

Comply By: 06/12/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

FOOD ON FLOOR IN STORAGE CLOSETS.

Comply By: 06/21/23

Food and Beverage Establishment Inspection Report

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DISCONTINUE KEEPING FRUITS AND VEGETABLES FOR MORE THAN 24 HOURS AFTER THEY ARE CUT.

Comply By: 06/12/23

7-200 Toxic Supplies and Applications

7-209.11

MN Rule 4626.1675 Store personal care items according to the rule.

STORE PERSONAL ITEMS SEPARATE FROM THE ESTABLISHMENT'S ITEMS.

Comply By: 06/12/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Juice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Jello
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Juice
Violation Issued: No

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

TALKED TO PIC AND KITCHEN STAFF ABOUT IMPORTANCE OF TAKING TEMPERATURES ON FOOD DELIVERIES WHEN THEY ARE DELIVERED.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1034231113 of 06/12/23.

Certified Food Protection Manager: Michelle Tollefson

Certification Number: FM110526 Expires: 04/13/25

Inspection report reviewed with person in charge and emailed.

Signed: emailed
Establishment Representative

Signed: McKenna Mathews

McKenna Mathews
Public Health Sanitarian 1
Fergus Falls District Office
218-332-5161
mckenna.mathews@state.mn.us