



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 30, 2025

Licensee
Goldpine Home
1700 30th Street Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30332016

Dear Licensee:

On October 2, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 23, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 23, 2025, found not corrected at the time of the October 2, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a) - \$500.00

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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 that reads "Benjamin Zwart". The signature is written in a cursive style with a large, stylized 'B' and a long, sweeping tail on the 'Z'.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/02/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
(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 SL30332016-2 On October 2, 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 July 15, 2025. At the time of the survey, there were 68 residents; 68 receiving services under the Assisted Living license. As a result of the follow-up survey, 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 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	{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 (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:	{0 470}			
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current:	{0 500}	Not reviewed during this survey.		

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{0 500}	Continued From page 2 (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks.	{0 500}			

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{0 500}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 500}	Not reviewed during this survey.		
{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 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:	{0 550}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:	{0 650}			

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{0 650}	Continued From page 4 (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; (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:	{0 650}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.	{0 775}	Not reviewed during this survey.		

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{0 775}	Continued From page 5 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). Findings include: On a facility tour on April 22, 2025, from 10:30 a.m. to 12:30 p.m., with facility maintenance manager (FMM)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: On July 14, 2025, at 12:31 p.m., an email was sent to FMM-C, requesting documentation the tags issued at the previous survey conducted on April 22, 2025, were corrected or a plan of correction was in place. A response to the email was received on July 15, 2025, at 9:21 a.m., indicating the following items were not corrected: On October 2, 2025, at 7:47 a.m., an email was sent to FMM-C, requesting documentation the tags issued at the previous survey conducted on July 14, 2025, were corrected. A response to the email was received on October 2, 2025, at 9:40 a.m., indicating the following items were not corrected: LIQUID OXYGEN STORAGE In an email received on October 2, 2025, at 9:40 a.m., FMM-C, provided a photo of liquid oxygen containers in a storage room exceeding the	{0 775}			

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{0 775}	Continued From page 6 allowable quantities of oxygen in a non-compliant oxygen storage room in accordance with MSFC in Minnesota Rules Chapter 7511. No further information was provided. FIRE RESISTANT RATED DOORS During the tour it was observed the door closer arms were removed from resident room doors throughout the facility and the storage room in the exit stairway on second floor between west addition and existing north building. Required fire-resistant rated doors are required to be maintained with self-closing hardware as designed and installed at the time of construction approval. Required fire-resistant rated doors shall be help open only with hardware tied into the building fire alarm system designed to release and close the door upon activation of the fire alarm system. In an email received on October 2, 2025, at 9:40 a.m., FMM-C, indicated the installation of door closers required on the fire-resistant rated doors was ongoing. No further information was provided. CARBON MONOXIDE ALARMS/ DETECTION There was a single station carbon monoxide alarm installed in the corridor outside the boiler room near the north entrance that was not tied into the building fire alarm system for notification. The carbon monoxide alarm sounded locally at the location of the activated alarm only.	{0 775}			

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{0 775}	Continued From page 7 No carbon monoxide detection or alarms were observed in the south building of the facility. There was not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility. Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. In an email received on October 2, 2025, at 9:40 a.m., FMM-C, indicated eight new carbon monoxide alarms will be installed near gas burning appliances and connected to the fire alarm panel. No further information was provided. EMERGENCY LIGHTING EXIT SIGN BACK UP POWER It was observed the combination exit emergency light was not provided with back up power when tested outside resident sleeping unit 7. It was observed the lighted exit signs in the north and south building did not have a button to test operation of the back up power system. During the tour FMM-C, stated they did not know how the exit light back up power system was tested. Emergency and exit lighting is required to be	{0 775}			

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{0 775}	Continued From page 8 provided with backup power to the lights and exit signs in order for occupants to for navigation to exits in the event of a power outage. In an email received on October 2, 2025, at 9:40 a.m., FMM-C, indicated emergency lighting and exit sign lighting upgrade installation is ongoing. No further information was provided.	{0 775}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}			

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{0 780}	Continued From page 9	{0 780}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	{0 810}			

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STATE FORM 6899 B46G13 If continuation sheet 11 of 20

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{01370}	Continued From page 11 (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	{01380}			

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{01380}	Continued From page 12 by:	{01380}	Not reviewed during this survey.		
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) 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; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	{01500}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/02/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
(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
{01500}	Continued From page 13 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=E	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.	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 14 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:	{01530}	Not reviewed during this survey.		
{01690} SS=F	144G.71 Subdivision 1 Medication management services	{01690}			

Minnesota Department of Health

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{01690}	Continued From page 15 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by:	{01690}	Not reviewed during this survey.		
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration	{01750}			

Minnesota Department of Health

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{01750}	Continued From page 16 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:	{01750}	Not reviewed during this survey.		
{01780} SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by:	{01780}			

Minnesota Department of Health

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{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 (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	{01790}			

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{01790}	Continued From page 18 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 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:	{01790}			
{01930} SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must	{01930}	Not reviewed during this survey.		

Minnesota Department of Health

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{01930}	Continued From page 19 address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by:	{01930}	Not reviewed during this survey.		
{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:	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 2, 2025

Licensee
Goldpine Home
1700 30th Street Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30332016

Dear Licensee:

On July 15, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 23, 2025, found not corrected at the time of the July 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00
0500-Policies And Procedures-144g.41 Subd. 2 - \$500.00
0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7 - \$500.00
0650-Staff Records-144g.42 Subd. 8 (a) - \$500.00
0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00
1370-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (a) - \$500.00
1380-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (b) - \$500.00
1500-Required Annual Training-144g.63 Subd. 5 - \$500.00
1530-Training In Dementia, Mental Illness, And De--144g.64 (a) (1-2) - \$500.00
1690-Medication Management Services-144g.71 Subdivision 1 - \$500.00
1750-Delegation Of Medication Administration-144g.71 Subd. 7 - \$500.00
1780-Medication Management For Residents Who Will-144g.71 Subd. 10 - \$500.00
1790-Medication Management For Residents Who Will-144g.71 Subd. 10 - \$500.00
1930-Policies And Procedures-144g.72 Subd. 2 - \$500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 15, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$7,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject

to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact 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,

A handwritten signature in cursive script that reads "Jessica Chenze". The ink is dark and the signature is fluid.

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/15/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30332016-1 On July 14, 2025, through July 15, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 23, 2025. At the time of the survey, there were 68 residents; 68 receiving services under the Assisted Living License. As a result of the follow-up survey, 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 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 post a daily work schedule at the beginning of each work shift with the required content. 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	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 2 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 held an assisted living license effective November 1, 2024, and was licensed for a capacity of 97, with a current census of 68 residents. On July 14, 2025, at 12:09 p.m., the surveyor observed the staff posting outside the nursing office on the north unit. It was four post-it notes behind a plastic cover, as follows: - "AM [morning] 6a [6:00 a.m.] - 2p [2:00 p.m.] North - Med cart nurse/med aide [unlicensed personnel/ULP] (T1) [Tier 1] - AM1 CNA/HHA [ULP] T1 - AM2 CNA/HHA 6 - 9:30 [6:00 a.m. - 9:30 a.m.] T1 6 - 2 [6:00 a.m. - 2:00 p.m.] T2 [Tier 2] - AM3 CNA/HHA T3 South - Med cart nurse/med aide (T1) - AM4 CNA/HHA T1 - AM5 CNA/HHA T1 6 - 8 [6:00 a.m. - 8:00 a.m.] T2 8 - 10 [8:00 a.m. - 10:00 a.m.] - AM6 CNA/HHA T3 West - Med cart nurse/med aide (T1/T2) - AM West One CNA/HHA T3 Tier 1 - census/case mix. Preferred level	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 3 Tier 2 - if needed - reduce to essential cares on specific group Tier 3 - other staff float In house 70 case mix 6/26/25 [June 26, 2025] - PM [evening] 2p [2:00 p.m.] - 10p [10:00 p.m.] North - Med cart nurse/med aide (T1) - PM1 CNA/HHA T1 - PM2 CNA/HHA 6-1 [6:00 a.m. - 1:00 p.m.] 6 -2 [6:00 a.m. - 2:00 p.m.] T2 - PM3 CNA/HHA T2 - T3 South - Med cart nurse/med aide (T1) - PM4 CNA/HHA T1 - PM5 CNA/HHA T1 2-8 [2:00 p.m. - 8:00 p.m.] - PM6 CNA/HHA T3 West - Med cart nurse/med aide (T1/T2) - PM West One CNA/HHA T3 T2 - West nurse/med aide might float from North or South - Night 10p-6a [10:00 p.m. - 6:00 a.m.] - Nurse Nurse - North CNA/HHA T1/T2 - South CNA/HHA T1/T2 - West CNA/HHA T2/T3 One CNA/HHA + [plus] 1 nurse essential only Include start and end times if not working full shift 6a-2p or 2p-10p or 10p-6a Thank you!"	{0 470}			

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{0 470}	Continued From page 4 On July 15, 2025, at 8:10 a.m., clinical nurse supervisor (CNS)-A stated the posting included the matrix of how they figured the staffing needs on their staffing plan. In addition, CNS-A stated the posting was not changed each day to indicate the actual staff working. No further information was provided.	{0 470}			
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or	{0 500}			

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{0 500}	Continued From page 5 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. 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: The licensee failed to ensure the following policies and procedures were in place and kept current:	{0 500}			

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{0 500}	Continued From page 6 - orientation. On July 15, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-A stated she had not developed or implemented the above policy. No further information was provided.	{0 500}			
{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 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 in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	{0 550}			

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{0 550}	Continued From page 7 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 July 14, 2025, at 12:15 p.m., the surveyor observed the posted Home Care Complaint information sheet, undated. It included the two staff names to contact with complaints. However, it lacked the email contact information. In addition, it lacked the contact information for Office of Ombudsman for Mental Health and Developmental Disabilities. On July 15, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-A stated the information was included on the bill of rights, but not the posted grievance procedure. No other information was provided.	{0 550}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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	{0 650}			

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{0 650}	Continued From page 8 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for four of four employees (licensed practical nurse/LPN-F, unlicensed personnel/ULP-H, ULP-J, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: LPN-F LPN-F was hired on November 20, 2020, to provide direct care services to residents of the facility.	{0 650}			

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{0 650}	Continued From page 9 LPN-F's employee record lacked documented evidence of an annual performance review that identified areas of improvement needed and training needs. ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents of the facility. ULP-H's employee record lacked documented evidence of an annual performance review that identified areas of improvement needed and training needs. ULP-J ULP-J was hired on January 10, 2020, to provide direct care services to residents of the facility. ULP-J's employee record lacked documented evidence of an annual performance review that identified areas of improvement needed and training needs. ULP-G ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked documented evidence of the following required training: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported; - recognizing physical, emotional, cognitive, and developmental needs of the resident. On July 15, 2025, at 11:05 a.m., licensed assisted living director (LALD)-B stated they were in the process of getting a staff support person in the	{0 650}			

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{0 650}	Continued From page 10 position to complete the annual reviews, but that person was currently training their replacement for the kitchen duties. LALD-B stated they had not done annual performance reviews for any staff at this point. On July 15, 2025, at 11:10 a.m., registered nurse (RN)-E stated the above required training had been provided but was not documented in the employee record for ULP-G. No further information was provided.	{0 650}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 22, 2025, from 10:30	{0 775}			

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{0 775}	Continued From page 11 a.m. to 12:30 p.m., with facility maintenance manager (FMM)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: On July 14, 2025, at 12:31 p.m., an email was sent to FMM-C, requesting documentation the tags issued at the previous survey conducted on April 22, 2025, were corrected or a plan of correction was in place. A response to the email was received on July 15, 2025, at 9:21 a.m., indicating the following items were not corrected: LIQUID OXYGEN STORAGE During the tour an oxygen storage room was observed containing 28 liquid oxygen storage containers. The containers were not restrained in the upright vertical position as required by the MSFC in Minnesota Rules Chapter 7511. Documentation shall be provided indicating the method and maximum quantities of aggregate storage of liquid oxygen within the oxygen storage room meets the requirements of the MSFC in Minnesota Rules Chapter 7511. FIRE RESISTANT RATED DOORS During the tour it was observed the door closer arms were removed from resident room doors throughout the facility and the storage room in the exit stairway on second floor between west addition and existing north building. Required fire-resistant rated doors are required to be maintained with self-closing hardware as designed and installed at the time of construction approval. Required fire-resistant rated doors shall be help open only with hardware tied into the	{0 775}			

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{0 775}	Continued From page 12 building fire alarm system designed to release and close the door upon activation of the fire alarm system. CARBON MONOXIDE ALARMS/ DETECTION There was a single station carbon monoxide alarm installed in the corridor outside the boiler room near the north entrance that was not tied into the building fire alarm system for notification. The carbon monoxide alarm sounded locally at the location of the activated alarm only. No carbon monoxide detection or alarms were observed in the south building of the facility. There was not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility. Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE The smoke alarm looked old, was chirping, had no date identifying manufacture date and did not test as required located outside the sleeping room in sleeping unit 8. The smoke alarm was removed by FMM-C, in resident sleeping unit 101and seven to verify year of manufacture. The manufacture date on the smoke alarms was 2010.	{0 775}			

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{0 775}	Continued From page 13 Smoke alarms are required to be maintained in working condition and replaced every ten years from the date of manufacture identified on the smoke alarm. FIRE RESISTANT RATED WALL MAINTENANCE There was a hole observed in the fire-resistant wall drywall membrane in the employee room near resident sleeping unit 107, and in the mechanical room above commercial kitchen. Fire-resistant rated wall membranes are required to be maintained as designed and installed at the time of construction approval. EMERGENCY LIGHTING EXIT SIGN BACK UP POWER It was observed the combination exit emergency light was not provided with back up power when tested outside resident sleeping unit 7. It was observed the lighted exit signs in the north and south building did not have a button to test operation of the back up power system. During the tour FMM-C, stated they did not know how the exit light back up power system was tested. Emergency and exit lighting is required to be provided with backup power to the lights and exit signs in order for occupants to for navigation to exits in the event of a power outage.	{0 775}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}			

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{0 810}	Continued From page 15 (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 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	{01370}			

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{01370}	Continued From page 16 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}			

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{01370}	Continued From page 17 Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked documented evidence of the following required training/competency testing: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - procedures to utilize in handling various emergency situations. On July 15, 2025, at 11:10 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-E stated the above required training for ULP-G had not been completed at this time.	{01370}			

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{01370}	Continued From page 18 No further information was provided.	{01370}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	{01380}			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
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{01380}	Continued From page 19 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked documented evidence of the following required training/competency testing: - range of motion and positioning. On July 15, 2025, at 11:10 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-E stated the above required training for ULP-G had not been completed at this time. No further information was provided.	{01380}			
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	{01500}			

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{01500}	Continued From page 20 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) 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; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01500}			

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{01500}	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel/ULP-H, ULP-J). 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: ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents of the facility. ULP-H's employee record lacked documented evidence of the following required annual training: - reporting maltreatment of vulnerable adults or minors; and - 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. ULP-J ULP-J was hired on January 10, 2020, to provide direct care services to residents of the facility. ULP-J's employee record lacked documented	{01500}			

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{01500}	Continued From page 22 evidence of the following required annual training: - reporting maltreatment of vulnerable adults or minors. On July 15, 2025, at 11:20 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-E stated the above training had been assigned but not completed by staff. No further information was provided.	{01500}			
{01530} SS=E	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 23 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 licensee failed to ensure two of three employees (unlicensed personnel/ULP-G, ULP-H) received the required amount of dementia care training in the required time frame. 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: The licensee provided services under an assisted living license.	{01530}			

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{01530}	Continued From page 24 ULP-G ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record contained documented evidence of 5.75 hours of training on topics related to dementia, short of the required eight hours within 160 working hours. ULP-G had reached 120 working hours on March 24, 2025. ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents at the facility. ULP-H's employee record contained documented evidence of 1.0 hours of training on topics related to dementia for each 12 months employment, short of the two hours training required. On July 15, 2025, at 11:25 a.m., licensed assisted living director (LALD)-B stated the training had been assigned, but ULP-G and ULP-H had not completed them yet. No further information was provided.	{01530}			
{01690} SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional,	{01690}			

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{01690}	Continued From page 25 or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). 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).	{01690}			

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{01690}	Continued From page 26 The findings include: The licensee failed to ensure the following policies and procedures were in place and kept current: - communicating with the resident and legal and designated representative; and - educating residents and legal and designated representatives about medications. On July 15, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated she had not developed or implemented the above policies. No further information was provided.	{01690}			
{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 interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for four of four residents (R1, R2,	{01750}			

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{01750}	Continued From page 27 R4, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R4, and R10's records lacked specific written instructions regarding the administration of medications, including as needed (PRN) medications ordered with a dosage range. R1 R1's diagnoses included diabetes mellitus type 2, obesity, and cellulitis. R1's Service Plan dated April 22, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's standing orders dated July 7, 2025, included: - Milk of Magnesia 1-2 ounces daily as needed; - Maalox 15-30 milliliters (ml) four times daily as needed; - Tylenol 325 milligrams (mg) 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. R2 R2's diagnoses included stroke.	{01750}			

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{01750}	Continued From page 28 R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's Standing Orders dated November 8, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed; - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. R4 R4's diagnoses included hypertension, and coronary artery disease. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, grooming, and medication administration. R4's Standing Orders dated May 22, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed; - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. R10 R10's diagnoses included dementia, atrial fibrillation, and dizziness. R10's Service Plan dated November 12, 2024, noted R10 received services including assistance with ambulation, bathing, dressing, and grooming.	{01750}			

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{01750}	Continued From page 29 R10's Standing Orders dated December 3, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed; - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. On July 14, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-A stated a new form was being developed without ranges, but has not been sent out to the providers for signatures yet. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy dated October 10, 2014, noted "If the prescription is for a PRN medication or a medication with a variable dosage, such as sliding scale insulin, the prescription must include specific parameters when to administer the medication and what dosage to administer." No further information was provided.	{01750}			
{01780} SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the	{01780}			

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{01780}	Continued From page 30 licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. 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: The licensee's Med Packaging for Time Away from Home (under 7 days) by Nurse or ULP (unlicensed personnel) policy dated May 11, 2025, lacked the following required content: - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); On July 14, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated the policy and procedure had been revised, but this part had been missed. No further information was provided.	{01780}			

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{01790}	Continued From page 31	{01790}			
{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 (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	{01790}			

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{01790}	Continued From page 32 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 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 comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	{01790}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/15/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
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{01790}	Continued From page 33 affect a large portion or all of the residents). The findings include: The licensee's Med Packaging for Time Away from Home (under 7 days) by Nurse or ULP (unlicensed personnel) policy dated May 11, 2025, lacked the following required content: - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel. On July 14, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated the policy and procedure had been revised, but this part of the procedure had been missed. No further information was provided.	{01790}			
{01930} SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and	{01930}			

Minnesota Department of Health

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{01930}	Continued From page 34 evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN). 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: The licensee's provided policies lacked: - educating and communicating with residents about treatments or therapies they are receiving. On July 15, 2025, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated she was unable to locate this in her policies and this piece had been missed. No further information was provided.	{01930}			
{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	{02310}			

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{02310}	Continued From page 35 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 provided according to acceptable health care and medical, or nursing standards for three of three residents (R2, R4, R10) with hospital bedrails. 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: R2 On July 15, 2025, at 8:15 a.m., the surveyor observed clinical nurse supervisor (CNS)-A measure R2's bed and bedrails as follows: - zone 1 (the area within the rails) ranging between 3.0 inches to 4.75 inches; - zone 2 (the area under the rail, between the rail supports or next to a single rail support) 0 inches; - zone 3 (the area between the rail and mattress) 1.0 inch; and - zone 4 (area under the rail, at the ends of the rail) 0 inches. R2's diagnoses included stroke.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 36 R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with ambulation, bathing, dressing, and medication administration. R2's Assessment dated June 27, 2025, indicated R2 required occasional assistance with ambulation and required assistance with bed mobility and sometimes with transfers. It noted R2 had knee pain. It indicated R2 had bilateral upper bedrails used for positioning, R2 was a fall risk, the bedrail met Food and Drug Administration (FDA) guidelines, and included measurements as follows: - zone 1 - 2.25 inches; - zone 2 - 2.25 inches; - zone 3 - 2.25 inch; and - zone 4 - 2.0 inches. R2's record lacked an assessment of the bedrail to include accurate measurements, documentation the bedrail was securely attached per manufacturer recommendations, and resident preferences. R4 R4's diagnoses included hypertension, bilateral cataracts, coronary artery disease, and joint pain in the lower leg. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, and medication administration. R4's Assessment dated July 3, 2025, noted R2 required assistance with ambulation, and bed mobility, including assistance sitting up at the edge of the bed and turning and repositioning. It noted R4 had a hospital bed with half side rails	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 37 with measurements as follows: - zone 1 - 2.25 inches; - zone 2 - 2.25 inches; - zone 3 - 2.25 inch; and - zone 4 - 2.25 inches. R4's record lacked an assessment of the bedrail to include the intended purpose and documentation the bedrail was securely attached to the bed frame per manufacturer guidelines. R10 On July 15, 2025, at 8:25 a.m., the surveyor observed CNS-A measure R10's bed and bedrails as follows: - zone 1 - 2.25 inches; - zone 2 - 0 inches; - zone 3 - 1.0 inch; and - zone 4 - 0 inches. R10's diagnoses included dementia, atrial fibrillation, and dizziness. R10's Service Plan dated November 12, 2024, noted R10 received services including assistance with ambulation, bathing, dressing, and grooming. R10's Assessment dated April 25, 2025, noted R2 was independent with ambulation, transfers, and bed mobility. It noted right shoulder pain. The assessment noted R10 had a hospital bed with one upper half rail with measurements as follows: - zone 1 - 2.25 inches; - zone 2 - 2.25 inches; - zone 3 - 2.25 inch; and - zone 4 - 2.25 inches. R10's record lacked an assessment of the bedrail to include accurate measurements and documentation the bedrail was securely attached	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 38 per manufacturer recommendations. On July 15, 2025, at 8:20 a.m., CNS-A stated she did not know why the correct measurements were not on the assessments, but would have to check into it. In addition, she noted the assessments lacked the above required content. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated July 1, 2025, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 39 risk agreements". The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

June 5, 2025

Licensee
Goldpine Home
1700 30th Street Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30332016

Dear Licensee:

Please Note: The attached state form has been amended with corrections to the tag identification 0420 on June 16, 2025.

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

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.

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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Goldpine Home. Please contact Jessie Chenze at 218-332-5175 on or before Tuesday, June 10, 2025, to schedule the conference call.

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 cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30332016-0 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 68 residents; 68 receiving services under the Assisted Living Facility license. Tag identification 0420 was amended with corrections on June 16, 2025.	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.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee rented out use of the facility space to operate a daycare. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 21, 2025, at 12:00 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was familiar with the current minimum assisted living requirements. On April 21, 2025, at 12:50 p.m., during the facility tour with LALD-B, the surveyor observed a common entry door off the west unit with a keypad system to enter from the common entry into the assisted living facility. LALD-B stated the facility rented out a space to a daycare which utilized the same main entrance, but had a separate entry into the daycare area. On April 22, 2025, at 1:00 p.m., the Minnesota Department of Health (MDH) engineer surveyor	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 stated the daycare and assisted living shared a building and had a one hour firewall between them. On April 23, 2025, at 9:30 a.m., CNS-A stated the daycare address was 1700B 30th Street NW, Bemidji, MN, and the facility address was 1700 30th Street NW, Bemidji, MN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 420 SS=F	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 facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 420			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
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0 420	Continued From page 4 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: The licensee had an assisted living license, effective November 1, 2024. 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/authorized agent on October 14, 2024. As a result of this survey, the following orders were issued under 0500, 0510, 0550, 0620, 0660, 1370, 1380, 1500, 1530, 1610, 1690, 1730, 1750, 1760, 1780, 1790, 1870, 1880, 1890, 1920, 1930, 1940, 2410, and 2480, which indicated the licensee's understanding of the Minnesota	0 420			

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0 420	Continued From page 5 statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	0 470			

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0 470	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to post a daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility held an assisted living license effective November 1, 2024, was licensed for a capacity of 97, with a current census of 68 residents. During the entrance conference on April 21, 2025, at 12:00 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they had varying shifts as follows: - days 6:00 a.m. to 2:00 p.m., some staff work 6:00 a.m. to 6:00 p.m., most days there are five staff, but the contingency plan is four staff, and can be two floats; - evenings 2:00 p.m. to 10:00 p.m., most days there are five staff, but the contingency plan is four staff, and can be two floats; and - night shift 10:00 p.m. to 6:00 a.m. two main staff but also a third mainly right now. Contingency plan can be two staff. On April 22, 2025, at 7:45 a.m., the surveyor	0 470			

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0 470	Continued From page 7 observed the staff posting outside the nursing office on the north unit. It was two post-it notes behind a plastic cover, one for the morning shift and one for the evening shift. The date listed was April 22, 2025. It noted the name of the staff and the location of their work assignment. However, it lacked a posting for the night shift and the hours worked. On April 22, 2025, at 9:45 a.m., CNS-A stated the daily posted schedule did not include the night shift or the hours each staff person worked. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced	0 485			

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0 485	Continued From page 8 by: Based on observation, interview, and record review, the licensee failed to make menus available to residents at least one week in advance. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 22, 2025, at 6:57 a.m., the surveyor observed the menu posted in the dining room on the north unit. The menu was identified as week three. No further menu was observed for the following week. On April 22, 2025, at 10:50 a.m., licensed assisted living director (LALD)-B stated only the menu for the current week was posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;	0 500			

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0 500	Continued From page 9 (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	0 500			

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0 500	Continued From page 10 Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. 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: During the entrance conference on April 21, 2025, at 12:00 p.m., the licensee's policies and procedures were requested. The provided policies lacked development of: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - ensuring that nurses and licensed health	0 500			

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0 500	Continued From page 11 professionals have current and valid licenses to practice; and - delegation of tasks by registered nurses or licensed health professionals. The licensee's Renewal Application Worksheet was dated October 14, 2024. On April 23, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated the licensee lacked the above required policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500			
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing	0 510			

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0 510	Continued From page 12 standards for infection control for three of four employees (unlicensed personnel/ULP-D, ULP-H, and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: On April 22, 2025, at 6:59 a.m., the surveyor observed ULP-D perform a blood glucose check on R9. ULP-D placed clean gloves, wiped R9's right ring finger with an alcohol wipe, poked the finger, wiped the blood, place blood on the test strip, and obtained a result. ULP-D then wiped R9's lower right abdomen with an alcohol wipe, administered Ozempic (an injectable medication to lower blood sugar). After assembling all supplies, ULP-D touched the door to exit the room, placed the needle and lancet in the sharps container, grabbed a wipe to clean the glucometer, placed it in the case, removed the keys from her pocket. ULP-D then opened the top drawer of the medication cart, placed supplies inside, went to the medication room and opened the door, opened the refrigerator, and placed the Ozempic inside, returned to the medication cart, opened the top drawer to look at the glucometer to check the result, touched the tablet to document the result, and at this point removed her gloves and utilized hand sanitizer.	0 510			

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0 510	Continued From page 13 On April 22, 2025, at 7:10 a.m., the surveyor observed ULP-D perform a blood glucose check on R1 in her room. ULP-D placed clean gloves, wiped the left middle finger, poked the finger, wiped the finger, placed a blood sample on the test strip, removed the gloves, turned off the light, opened the door, and grabbed a wipe to clean the glucometer. ULP-D then placed the glucometer in the medication cart after getting her keys from her pocket and opening the medication cart, touched the medication cassettes, documented the medication administration, and at this point utilized hand sanitizer. On April 22, 2025, at 7:35 a.m., ULP-D stated she was trained to sanitize her hands or wash them after removing her gloves before touching anything after doing a blood glucose check. On April 22, 2025, at 1:08 p.m., the surveyor observed ULP-H assist R2 in the bathroom. While R2 was sitting on the toilet, ULP-H placed clean gloves, removed a wet brief, placed a clean brief, pulled up R2's pants to above her knees, removed the trash bag, tied it, and placed a clean bag in the trash can. At this point, ULP-H changed her gloves, assisted R2 to stand, performed perineal cares with a wet wipe on the back side going in both a front to back and back to front motion. After doing this several times, ULP-H grabbed a new wet wipe and provide perineal cares on the front in a back to front motion. ULP-H then pulled up R2's brief and pants, flushed the toilet, touched the back of the wheelchair, touched the transfer belt and at this point removed the gloves and placed new gloves without performing hand hygiene. ULP-H then opened the bathroom door, pushed R2 in the wheelchair to the sink, washed R2's hands, removed paper towels form the roll to wipe R2's	0 510			

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0 510	Continued From page 14 hands and pushed R2 in the wheelchair out of the bathroom. At this point, ULP-H removed the gloves and washed her hands. Upon exiting the room, ULP-H stated she should have performed hand hygiene after removing the gloves and after performing perineal cares on a resident. On April 23, 2025, at 7:25 a.m., the surveyor observed ULP-G assist R3 with toileting. ULP-G assisted R3 to the toilet, removed the brief slightly soiled with feces, and placed a clean brief, socks, pants, and shoes on, removed the old shirt and placed a clean shirt on R3. ULP-G then assisted R3 off the toilet and assisted her to stand and hold the rail, and performed perineal cares in the back with a back to front motion, pulled up R3's brief and pants, pulled down the shirt, and assisted R3 to sit in the wheelchair. At this time, ULP-G removed the gloves, flushed the toilet, pushed the wheelchair to the sink, combed R3's hair, turned on the water in the sink to wet the comb, assisted R3 to stand at the sink to see her hair in the mirror and to sit back down, opened the door and pushed R3 out into the hallway, stopped at the laundry room and opened the door with a code, placed a bag inside, and upon exiting the laundry room, utilized hand sanitizer. On April 22, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated staff are expected to either sanitize or wash their hands after performing a blood glucose check and every time gloves are removed. CNS-A also stated perineal cares should be performed from front to back only. The licensee's Handwashing policy dated January 3, 2002, instructed staff to "Wash hands frequently, whenever beginning or ending cares or a procedure to prevent the spread of germs to	0 510			

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0 510	Continued From page 15 yourself and others." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 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 in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550			

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0 550	Continued From page 16 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: During the facility tour on April 21, 2025, at 12:50 p.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entry to the facility with the dining room, common sitting area, and hallways with resident rooms. The facility had three units; north, south, and west, with the west being the newest addition. During the tour, the facility's grievance procedure including the name, telephone number, and email contact information for the individuals responsible for handling resident grievances was not observed. The licensee's Home Care Complaint document dated January 2016, lacked the email contact information for the individuals responsible for handling resident grievances. In addition, it lacked the contact information for Office of Ombudsman for Mental Health and Developmental Disabilities. On April 22, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated the grievance procedure was posted inside the resident rooms, and lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
(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
0 650 SS=E	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; (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 observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (licensed practical nurse/LPN-F, unlicensed personnel/ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 650			

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0 650	Continued From page 18 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: LPN-F LPN-F was hired on November 20, 2020, to provide direct care services to residents of the facility. LPN-F's employee record lacked documented evidence of an annual performance review that identified areas of improvement needed and training needs. ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents of the facility. ULP-H's employee record lacked documented evidence of an annual performance review that identified areas of improvement needed and training needs. On April 23, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated annual training reviews had not been completed as required for these two employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

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0 660	Continued From page 19 (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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel/ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 660			

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0 660	Continued From page 20 The findings include: The licensee's Facility TB Risk Assessment dated January 15, 2025, indicated the licensee was a low risk level. ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record contained a TST dated administered on March 6, 2025, and read on March 9, 2025. However, it lacked documented evidence of a second step TST. On April 23, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-A stated the paperwork for ULP-G's TST was hanging on a board to be completed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 21	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a	0 680			

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0 680	Continued From page 22 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: During the facility tour on April 21, 2025, at 12:50 p.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entry to the facility with the dining room, common sitting area, and hallways with resident rooms. The facility had three units; north, south, and west, with the west being the newest addition. The licensee's lime green GoldPine Home Emergency Preparedness binder, dated reviewed November 19, 2024, lacked the following required content: - quarterly review of the missing resident plan; - policy and procedure to address alternative sources of energy to maintain temperatures to protect resident health/safety and sewage; - EP training and testing program that must be reviewed and updated annually; - training program to include initial training of new staff and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role and at least annually; - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if	0 680			

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0 680	Continued From page 23 the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On April 23, 2025, at 1:30 p.m., LALD-B and clinical nurse supervisor (CNS)-A stated the plan lacked the above required content and training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 775			

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0 775	Continued From page 24 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). Findings include: On a facility tour on April 22, 2025, from 10:30 a.m. to 12:30 p.m., with facility maintenance manager (FMM)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: LIQUID OXYGEN STORAGE During the tour an oxygen storage room was observed containing 28 liquid oxygen storage containers. The containers were not restrained in the upright vertical position as required by the MSFC in Minnesota Rules Chapter 7511. Documentation shall be provided indicating the method and maximum quantities of aggregate storage of liquid oxygen within the oxygen storage room meets the requirements of the MSFC in Minnesota Rules Chapter 7511. FIRE RESISTANT RATED DOORS During the tour it was observed the door closer arms were removed from resident room doors throughout the facility and the storage room in the exit stairway on second floor between west addition and existing north building. Required fire-resistant rated doors are required to be maintained with self-closing hardware as designed and installed at the time of construction	0 775			

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0 775	Continued From page 25 approval. Required fire-resistant rated doors shall be help open only with hardware tied into the building fire alarm system designed to release and close the door upon activation of the fire alarm system. SPACE HEATER POWER During the tour a space heater was observed plugged in to an extension cord to provide power to the space heater in resident sleeping unit 101. Space heaters shall be plugged directly into a wall power outlet and or used in accordance with manufactures instructions and MSFC in Minnesota Rules Chapter 7511. CARBON MONOXIDE ALARMS/ DETECTION There was a single station carbon monoxide alarm installed in the corridor outside the boiler room near the north entrance that was not tied into the building fire alarm system for notification. The carbon monoxide alarm sounded locally at the location of the activated alarm only. No carbon monoxide detection or alarms were observed in the south building of the facility. There was not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility. Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules	0 775			

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0 775	Continued From page 26 Chapter 7511. SMOKE ALARM MAINTENANCE The smoke alarm looked old, was chirping, had no date identifying manufacture date and did not test as required located outside the sleeping room in sleeping unit 8. The smoke alarm was removed by FMM-C, in resident sleeping unit 101 and seven to verify year of manufacture. The manufacture date on the smoke alarms was 2010. Smoke alarms are required to be maintained in working condition and replaced every ten years from the date of manufacture identified on the smoke alarm. FIRE RESISTANT RATED WALL MAINTENANCE There was a hole observed in the fire-resistant wall drywall membrane in the employee room near resident sleeping unit 107, and in the mechanical room above commercial kitchen. Fire-resistant rated wall membranes are required to be maintained as designed and installed at the time of construction approval. SECURING OF COMPRESSED GAS CYLINDERS There were compressed gas carbon dioxide cylinders in the commercial kitchen area that were not secured in the upright position to prevent from tipping. It was explained to FMM-C, that compressed gas	0 775			

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0 775	Continued From page 27 cylinders are required to be secured in the upright position to prevent tipping and damage to the top valve assembly. EMERGENCY LIGHTING EXIT SIGN BACK UP POWER It was observed the combination exit emergency light was not provided with back up power when tested outside resident sleeping unit 7. It was observed the lighted exit signs in the north and south building did not have a button to test operation of the back up power system. During the tour FMM-C, stated they did not know how the exit light back up power system was tested. Emergency and exit lighting is required to be provided with backup power to the lights and exit signs in order for occupants to for navigation to exits in the event of a power outage. STORAGE IN EXIT PATHS Furniture and equipment were observed in the exit path near resident sleeping unit 225. The required marked exit paths shall be kept free of obstructions that prevent full and immediate use of the exit path. The required exit paths shall only be used for the purpose of exiting in the event of a fire or similar emergency. ELECTRICAL AND EQUIPMENT COVER MAINTENANCE There was an electrical power outlet cover missing in the employee room near resident sleeping unit 107 and on the electrical junction box in the mechanical room near resident	0 775			

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0 775	Continued From page 28 sleeping unit 101. All covers on electrical power equipment are required to be maintained in place to prevent contact to electrical power by building occupants. The equipment covers were not installed on the water heater in the mechanical room near resident sleeping unit 101. All mechanical equipment covers are required to be maintained in place in accordance with equipment manufactures instructions and MSFC in Minnesota Rules Chapter 7511. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms and interconnected smoke alarms throughout the facility. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include: SMOKE ALARM INTERCONNECTION On a facility tour on April 22, 2025, at 10:45 a.m. to 12:15 p.m., with facility maintenance manager (FMM)-C, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in resident sleeping units 7, 8, and 9 on the second floor. Each sleeping unit was provided with multiple smoke alarms as required but when tested by FMM-C, the smoke alarms within each sleeping unit were not interconnected. All sleeping units required to have multiple smoke alarms are required to have interconnected	0 780			

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0 780	Continued From page 30 alarms so activation of one alarm activates all alarms within the sleeping unit. During the tour the smoke alarms were tested and FMM-C, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. SMOKE ALARMS OUTSIDE OF SLEEPING ROOMS On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of the sleeping room in resident sleeping unit 7. During the tour it was observed the smoke alarm outside the sleeping room in sleeping unit 7 was located in the kitchenette area which was separated from the bedroom hallway by a header with a depth of fourteen inches down from the ceiling. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. The required smoke alarm installed outside the sleeping room shall not be separated by construction that prevents the flow of smoke to the smoke alarm. During the tour FMM-C, verified smoke alarms were not installed outside in the immediate vicinity of the sleeping room in resident sleeping unit 7. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 31 (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 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to	0 810			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601		
(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
0 810	Continued From page 32 directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on, April 22, 2025, at 9:30 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in an electronic file and had to be printed in order to provide for review. On April 22, 2025, at 9:30 a.m., licensed assisted living director (LALD)-B, 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 provided FSEP dated June 5, 2009, failed to include the following: The available FSEP was developed but the plan was dated June 5, 2009, and did not indicate it had been updated since. The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of residents for evacuation. The FSEP failed to include evacuation status and unique needs for	0 810			

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0 810	Continued From page 33 evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on April 22, 2025, at 9:45 a.m., LALD-B, stated the evacuation status unique needs for individual resident evacuation was available electronically but not available for immediate reference in writing within the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation employees were trained upon hire, but documentation was not available indicating training was provided twice per year after hire. During an interview on April 22, 2025, at 9:50 a.m., LALD-B, stated documentation was not available indicating employee training was completed twice per year after hire for each employee. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation the required fire evacuation drills were completed.	0 810			

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0 810	Continued From page 34 During an interview on April 22, 2025, at 9:55 a.m., LALD-B, stated documentation was not available indicating fire evacuation drills were completed as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950			

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0 950	Continued From page 35 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three residents (R1, R3, R4) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's start of services was March 22, 2024. R1's Resident Agreement, identified as the contract, was signed by R1 on March 22, 2024. R3 R3's start of services was April 1, 2024. R3's Resident Agreement was signed by R3 on March 17, 2024. R4 R4's start of services was May 17, 2024. R4's Resident Agreement was signed by R4's legal representative on May 21, 2024.	0 950			

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0 950	Continued From page 36 R1, R3, and R4's Resident Agreement lacked the following required verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On April 22, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated the contract utilized for all residents lacked the required verbatim notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060			

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01060	Continued From page 37 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for three of three residents (R2, R3, R4), and failed to notify the Office of	01060			

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01060	Continued From page 38 Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for two of three residents (R2, R4) who were hospitalized. 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: R2 R2's diagnoses included stroke. R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's Resident Notes included the following: - April 16, 2025, R2 transferred to the emergency room (ER) and was admitted with a diagnosis of pneumonia; - April 17, 2025, R2 admitted with diagnoses of pneumonia and severe anemia. Antibiotic therapy started and R2 participated in physical therapy/occupational therapy (PT/OT); and - April 21, 2025, R2 switched to oral antibiotics and received two units of blood and a three day course of iron infusion. On April 22, 2025, at 1:08 p.m., the surveyor observed ULP-H assist R2 in the bathroom. ULP-H stated R2 had returned from the hospital earlier this shift.	01060			

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01060	Continued From page 39 R3 R3's diagnoses included Parkinson's disease and anxiety. R3's Service Plan dated April 1, 2024, noted R3 received services including assistance with bathing, dressing, and medication administration. R3's Resident Notes included the following: - February 26, 2025, R3 fell and was sent to the ER and was admitted; - February 27, 2025, R3 returned from the hospital. R4 R4's diagnoses included hypertension, and coronary artery disease. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, grooming, and medication administration. R4's Resident Notes included the following: - February 13, 2025, R4 admitted to the hospital for an infection; - February 25, 2025, R4 returned to the facility. R2, R3, and R4's records lacked evidence the facility had provided a written notice upon emergency relocation which included, at a minimum: -the reason for the relocation; -the name and contact information of the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and	01060			

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01060	Continued From page 40 Developmental Disabilities (OOMHDD); -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to repeal under section 144G.54. Additionally, the notice must be delivered to the OOLTC if the resident has been relocated and has not returned to the facility within four days. On April 22, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated emergency relocations had not been completed for residents admitted to the hospital, and a relocation had not been sent to the OOLTC for R2 or R4. CNS-A stated her process was to call and notify family if a resident was hospitalized. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment;	01370			

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01370	Continued From page 41 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01370			

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01370	Continued From page 42 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked documented evidence of the following required training/competency testing: - documentation requirements 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; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - procedures to utilize in handling various emergency situations. On April 23, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-A stated the licensee had a checklist used to document all required training and competency testing, but this was not completed for ULP-G. No further information was provided.	01370			

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01370	Continued From page 43	01370			
01380 SS=D	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01380			

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01380	Continued From page 44 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked documented evidence of the following required training/competency testing: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motion and positioning. On April 23, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-A stated the licensee had a checklist used to document all required training and competency testing, but this was not completed for ULP-G. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 45 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) 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; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
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01500	Continued From page 46 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (licensed practical nurse/LPN-F, unlicensed personnel/ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: LPN-F LPN-F was hired on November 20, 2020, to provide direct care services to residents of the facility. LPN-F's employee record lacked documented	01500			

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01500	Continued From page 47 evidence of the following required annual training: - review of provider's policies and procedures; and - principles of person-centered planning and service delivery. ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents of the facility. ULP-H's employee record lacked documented evidence of the following required annual training: - reporting maltreatment of vulnerable adults or minors; - 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; and - review of provider's policies and procedures. On April 23, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated the required training had not been completed by LPN-F or ULP-H. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	01530			

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01530	Continued From page 48 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel/ULP-G, ULP-H) received the required amount of dementia care training in the required time frame. 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).	01530			

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01530	Continued From page 49 The findings include: The licensee provided services under an assisted living license. ULP-G ULP-G was hired on March 6, 2025, to provide direct care services to residents of the facility. ULP-G's employee record lacked evidence ULP-G had completed the required eight hours of initial training within 120 working hours. On April 23, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-A stated ULP-G had not completed any dementia training at this point, and licensed assisted living director (LALD)-B stated ULP-G had reached 120 working hours on March 24, 2025. ULP-H ULP-H was hired on October 2, 2020, to provide direct care services to residents at the facility. ULP-H's employee record contained documented evidence of 1.5 hours of training on topics related to dementia for each 12 months employment, short of the required two hours training required. On April 23, 2025, at 2:00 p.m., CNS-A stated the required amount of training was assigned, but ULP-H must not have done it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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01560	Continued From page 50	01560			
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required 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; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01560			

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01560	Continued From page 51 The licensee provided services under an assisted living license. The licensee's undated Dementia/Alzheimer's Training document provided as the dementia disclosure lacked the following required content: - categories of employees trained; - frequency of training; and - basic topics covered to include person-centered planning and service delivery. On April 22, 2025, at 11:15 a.m., licensed assisted living director (LALD)-B stated the form lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	01610			

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01610	Continued From page 52 based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 admitted for services on May 17, 2024, with diagnoses including hypertension, and coronary artery disease. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, grooming, and medication administration. R4's record included an Admission Assessment, dated June 14, 2024, or 28 days after R4's admission date, not prior to the date on which a prospective resident executed a contract with a facility or the date no which a prospective resident moves in, whichever was earlier, as required.	01610			

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01610	Continued From page 53 On April 23, 2025, at 8:20 a.m., clinical nurse supervisor (CNS)-A stated it was possible she started the assessment but did not finish it until June 14, 2024. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about	01690			

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01690	Continued From page 54 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). 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: During the entrance conference on April 21, 2025, at p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's provided policies lacked: - documenting medication management activities; - controlling and storing medications; - communicating with the resident and legal and designated representative; and - educating residents and legal and designated representatives about medications.	01690			

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01690	Continued From page 55 On April 23, 2025, at 12:20 p.m., CNS-A stated the licensee did not have the above required policies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730			

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01730	Continued From page 56 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility.	01730			

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01730	Continued From page 57 R1 R1's diagnoses included diabetes mellitus type 2, obesity, and cellulitis. R1's Service Plan dated March 22, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated April 10, 2025, included two antihypertensives (to lower blood pressure), insulin, and a pain reliever. R1's April 2025, Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials on each date through April 21, 2025, to indicate the medications had been given. On April 22, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R1's Individualized Medication Management Plan dated March 21, 2025, lacked the following required content: - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2 R2's diagnoses included stroke.	01730			

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01730	Continued From page 58 R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's prescriber orders dated April 21, 2025, included a diuretic, a pain reliever, and an antihypertensive medication. R2's April 2025, Med Admin Summary listed medications as prescribed, times to administer, and staff initials on each date through April 21, 2025, to indicated the medications had been given. On April 22, 2025, at 1:08 p.m., the surveyor observed ULP-H assist R2 in the bathroom. R2's Individualized Medication Management Plan dated March 21, 2025, lacked the following required content: - identification of medication management tasks that may be delegated to unlicensed personnel. R3 R3's diagnoses included Parkinson's disease and anxiety. R3's Service Plan dated April 1, 2024, noted R3 received services including assistance with bathing, dressing, and medication administration. R3's prescriber orders dated March 7, 2025, included an antipsychotic medication, an antidepressant, and a pain reliever. R3's April 2025, Med Admin Summary listed medications as prescribed, times to administer, and staff initials on each date through April 21,	01730			

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01730	Continued From page 59 2025, to indicated the medications had been given. On April 23, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F administer R3's medications to her in the dining room. R3's Individualized Medication Management Plan dated March 21, 2025, lacked the following required content: - identification of medication management tasks that may be delegated to unlicensed personnel. R4 R4's diagnoses included hypertension, and coronary artery disease. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, grooming, and medication administration. R4's prescriber orders dated February 28, 2025, included an antibiotic, one pain medication, and one multivitamin. R4's April 2025, Med Admin Summary listed medications as prescribed, times to administer, and staff initials on each date through April 21, 2025, to indicated the medications had been given. R1's Individualized Medication Management Plan dated March 21, 2025, lacked the following required content: - identification of medication management tasks that may be delegated to unlicensed personnel. On April 22, 2025, at 3:00 p.m., CNS-A stated she	01730			

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01730	Continued From page 60 typically puts a statement in the notes to include all this information, but it was missed with these residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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 interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01750			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
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01750	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: R1, R2, R3, and R4's records lacked specific written instructions regarding the administration of medications, including as needed (PRN) medications ordered with a dosage range. R1 R1's diagnoses included diabetes mellitus type 2, obesity, and cellulitis. R1's Service Plan dated March 22, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated April 10, 2025, included acetaminophen 500 milligrams (mg) by mouth for mild pain. Give 1-2 tablets three times per day at 8:00 a.m., 1:00 p.m., and 8:00 p.m. On April 22, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R2 R2's diagnoses included stroke. R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's Standing Orders dated November 8, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed;	01750			

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01750	Continued From page 62 - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. R3 R3's diagnoses included Parkinson's disease and anxiety. R3's Service Plan dated April 1, 2024, noted R3 received services including assistance with bathing, dressing, and medication administration. R3's Standing Orders dated March 21, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed; - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. On April 23, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F administer R3's medications to her in the dining room. R4 R4's diagnoses included hypertension, and coronary artery disease. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, grooming, and medication administration. R4's Standing Orders dated May 22, 2024, included: - Milk of Magnesia 1-2 ounces daily as needed;	01750			

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01750	Continued From page 63 - Maalox 15-30 ml four times daily as needed; - Tylenol 325 mg 1-2 tablets every four hours as needed; and - Robitussin DM 5-10 ml every four hours four times a day as needed. On April 22, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated the medications should not include a range. In addition, CNS-A stated the standing orders included ranges and would need to be changed. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy dated October 10, 2014, noted "If the prescription is for a PRN medication or a medication with a variable dosage, such as sliding scale insulin, the prescription must include specific parameters when to administer the medication and what dosage to administer." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760			

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01760	Continued From page 64 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 verify accuracy of prescriber orders when transcribing orders for one of four 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's diagnoses included diabetes mellitus type 2, obesity, and cellulitis. On April 22, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R1's Service Plan dated March 22, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated April 10, 2025, included: - Tessalon 200 milligrams (mg) three times a day as needed "[resident's name] requests this med	01760			

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01760	Continued From page 65 [medication] every HS [evening], so we are placing it in a scheduled spot." R1's April 2025, Med (Medication) Admin (Administration) Summary included: - Tessalon 200 mg three times a day as needed (PRN) "[resident's name] requests this med [medication] every HS [evening], so we are placing it in a scheduled spot." This medication is placed with an 8:00 p.m. administration time. However, there is no documentation of this medication under the PRN section. On April 22, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated the medication should have been transcribed under the PRN section, and added this way of documenting everything together was a transcription error. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and	01780			

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01780	Continued From page 66 federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. 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: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Sending Residents out with Medications policy dated July 1, 2002, lacked the following required content: - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); - 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: and	01780			

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01780	Continued From page 67 - the resident must be provided written information on medications including any special instructions for administering and handling the medications, including controlled substances. On April 23, 2025, at 12:40 p.m., CNS-A stated the licensee did not have a policy with this required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780			
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 (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	01790			

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01790	Continued From page 68 (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 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	01790			

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01790	Continued From page 69 (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. The licensee lacked written procedures to include: - written information about the medications to be provided; - how the ULP 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, there person who provided the medications to the resident, the number of medications that were provided to the resident and other required information; - 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;	01790			

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01790	Continued From page 70 - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and - 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. On April 23, 2025, at 12:40 p.m., CNS-A stated she had not developed written procedures with this required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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 residents were assessed for self-administration of medications for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01870			

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01870	Continued From page 71 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: R6's diagnoses included depression, chronic obstructive pulmonary disease, emphysema, dementia, anxiety, pulmonary hypertension, chronic respiratory failure, and Parkinson's disease. R6's Service Plan dated November 13, 2024, noted R6 received services including assistance with bathing, dressing, grooming, medication administration, and oxygen delivery. R6's Assessment dated January 27, 2025, noted medication self administration was "not applicable". On April 22, 2025, at 7:45 a.m., the surveyor observed R6 in her room, visible from the hallway, with a nebulizer mask placed over mouth and heard to be running. R6's eyes were closed, and no staff were in the area. The surveyor continuously observed R6, and at 7:51 a.m., licensed practical nurse (LPN)-F entered R6's room and removed the nebulizer mask from R6's face. LPN-F then wheeled R6 out to the dining room for breakfast. On April 22, 2025, at 7:55 a.m., LPN-F stated she always leaves R6 to independently administer the nebulizer after she sets it up and starts the machine. LPN-F stated she was not sure if R6 was assessed to be able to administer the	01870			

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01870	Continued From page 72 nebulizer medication independently, and said that was just how they have always done it. On April 22, 2025, at 8:10 a.m., clinical nurse supervisor (CNS)-A stated staff look at R6 each day, and if she is alert, they can leave her with the nebulizer in place. CNS-A stated R6 had not been assessed to administer the nebulizer independently. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870			
01880 SS=D	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 medications were secure and permitted access to only authorized personnel for one of three medication rooms. 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	01880			

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01880	Continued From page 73 situation has occurred only occasionally). The findings include: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. On April 22, 2025, at 7:21 a.m., and 7:32 a.m., the surveyor observed the West unit's medication room door open and no staff in sight when returning from observing ULP-D provide medication administration in a resident room. Prior to entering the first resident's room, registered nurse (RN)-E had been sitting at the desk just outside the medication room. Residents were observed coming and going in the common area near the medication room. On April 22, 2025, at 7:38 a.m., RN-E stated she usually closes the door when leaving the area, and said the unlocked cabinets do have medications in them. In addition, the medication refrigerator inside the medication room was not locked. On April 22, 2025, at 7:45 a.m., CNS-A stated the medication room doors were to be locked at all times when staff are not present in the area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890			

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01890	Continued From page 74 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: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of seven residents (R7, R8). 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 April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. On April 23, 2025, at 11:20 a.m., the surveyor observed medication storage on the south unit with registered nurse (RN)-I, with the following: - R7's insulin glargine vial lacked a prescription label; and - R8's Novolog FlexPen (prefilled insulin pen) lacked a prescription label.	01890			

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01890	Continued From page 75 At this time, RN-I stated she was not sure what happened to the package for the insulin vial, and stated the insulin pens came from the pharmacy with the prescription label on the box, not each individual pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement procedures for loss and spillage of all	01920			

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01920	Continued From page 76 controlled substances defined in Minnesota Rules part 6800.4220. 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: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents, including storage of controlled substances. On April 23, 2025, at 12:30 p.m., CNS-A stated she believed she had a loss and spillage policy on her computer but it was not accessible to staff. However, this was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920			
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed	01930			

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01930	Continued From page 77 under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN). 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: During the entrance conference on April 21, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to the licensee's residents. The licensee's provided policies lacked:	01930			

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01930	Continued From page 78 - documenting treatment or therapy activities; and - educating and communicating with residents about treatments or therapies they are receiving. On April 23, 2025, at 12:35 p.m., CNS-A stated the licensee did not have the above required policies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940			

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01940	Continued From page 79 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided for one of one resident (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: During the entrance conference on April 21, 2025, at 11:15 12:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to residents at the facility. R1's diagnoses included diabetes mellitus type 2, obesity, and cellulitis. On April 22, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room.	01940			

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01940	Continued From page 80 R1's Service Plan dated March 22, 2024, indicated R1 received services including assistance with bathing and medication administration. However, it did not include blood glucose monitoring. R1's prescriber orders dated April 10, 2025, included an order for a sliding scale correction dose of Humalog according to the blood glucose result, three times a day. R1's Service Recap Summary for April 2025, instructed staff to record blood glucose daily at 7:00 a.m., 11:00 a.m., and 4:00 p.m. On April 22, 2025, at 3:30 p.m., CNS-A stated R1's blood glucose monitoring was not included on the service plan and must have been missed. The licensee's Service Plan Contents policy dated October 19, 2018, noted the service plan would include a description of the services and frequency of each service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
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	02310			

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02310	Continued From page 81 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with an assistive device (consumer bedrail), and two of two residents (R2, R4) with hospital bedrails. 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: CONSUMER BEDRAIL On April 23, 2025, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R3 with morning cares. The surveyor observed R3 when entering the room to be in bed on her right side. The twin sized bed had a mattress on top of a box spring. The mattress was not centered, with approximately four inches of the box spring showing on the right side of the bed. The left side of the bed was against the wall. The white metal assistive device was an upside-down U shaped rail with two horizontal rails in the middle that were covered with a mesh pocket. There was a handle that stuck out along the outside parallel with the bed to hold while using. The white metal was covered with a black cloth around the bars, with only a small amount of white showing. R3 did hold the rail while sitting up, but did not use it while transferring to the	02310			

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02310	Continued From page 82 wheelchair. R3's diagnoses included Parkinson's disease, mild cognitive impairment, hallucinations, myopia, insomnia, action tremor, and low back pain. R3's Service Plan dated April 1, 2024, noted R3 received services including assistance with ambulation, bathing, dressing, and transferring. R3's Assessment dated April 6, 2025, indicated R3 required assistance with ambulation and transfers, and indicated R3 was independent with bed mobility. It noted R3 had bladder incontinence. It indicated R3 had a twin bed with a grab bar (consumer bedrail) on the right side of the bed. R3's undated Side Rail (consumer bedrail) Use Assessment Form noted R3 was non-ambulatory, had an alteration in safety awareness due to cognitive decline, had a history of falls, displayed poor bed mobility or difficulty moving from a sitting position on the side of the bed, had difficulty with balance, utilized the bedrail for positioning or support, and was visually challenged. Recommendations included a grab bar on the right side of the bed to enable or promote independence. R3's record included a Risk Agreement - Bed Rails which indicated the purpose of was to assisted getting in or out of bed and assist with repositioning. However, this was not dated or signed. On April 23, 2025, at 8:05 a.m., the surveyor observed the bed and assistive device with clinical nurse supervisor (CNS)-A. CNS-A was able to adjust the mattress and bed to be tight	02310			

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02310	Continued From page 83 against the wall on the left side, with the consumer bedrail on the right side of the bed, and lifted the mattress to observe the device was attached per manufacturer guidelines. CNS-A stated the mattress and bed should be pressed against the wall on the left side. R3's record lacked an assessment of the bedrail to include evidence the bedrail had been checked for a recall, the condition/description of the bedrail, whether or not the bedrail had the effect of being an improper restraint, and whether the bedrail was securely attached to the bed frame per manufacturer guidelines. HOSPITAL BEDRAILS R2 On April 22, 2025, at 1:30 p.m., the surveyor observed CNS-A measure R2's bed and bedrails as follows: - zone 1 (the area within the rails) ranging between 3.0 inches to 4.5 inches; - zone 2 (the area under the rail, between the rail supports or next to a single rail support) 0 inches; - zone 3 (the area between the rail and mattress) 1.0 inch; and - zone 4 (area under the rail, at the ends of the rail) 0 inches. At this time, CNS-A stated this was a different rail than she had assessed previously, and she was not aware when it had been changed. R2's diagnoses included stroke. R2's Service Plan dated November 7, 2024, noted R2 received services including assistance with ambulation, bathing, dressing, and medication administration.	02310			

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02310	Continued From page 84 R2's Assessment dated April 4, 2025, indicated R2 required assistance with ambulation and "sometimes" required assistance with bed mobility and transfers. It noted R2 had bladder incontinence and knee pain. It indicated R2 had bilateral upper bedrails used for positioning, R2 was a fall risk, the bedrail met Food and Drug Administration (FDA) guidelines, and included measurements as follows: - zone 1 - 2.25 inches; - zone 2 - 2.25 inches; - zone 3 - 2.25 inches; and - zone 4 - 2.0 inches. R2's record lacked an assessment of the bedrail to include accurate measurements, documentation the bedrail was securely attached per manufacturer recommendations, and resident preferences. R4 R4's diagnoses included hypertension, bilateral cataracts, coronary artery disease, and joint pain in the lower leg. R4's Service Plan dated June 5, 2024, noted R4 received services including assistance with ambulation, bathing, dressing, and medication administration. R4's Assessment dated April 7, 2025, noted R2 required assistance with ambulation, and bed mobility, including assistance sitting up at the edge of the bed and turning and repositioning. It noted R4 had bladder incontinence, and had a hospital bed with half side rails with measurements noted to be within the FDA guidelines. R4's record lacked an assessment of the bedrail	02310			

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02310	Continued From page 85 to include the intended purpose, whether or not the bedrails had the effect of being an improper restraint, whether they were securely attached to the bed frame per manufacturer guidelines, the risk versus benefits of the bedrails, and the resident's preferences. On April 23, 2025, at 8:20 a.m., CNS-A stated the resident assessments lacked the above required content. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for	02310			

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02310	Continued From page 86 areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) also indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of	02410			

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02410	Continued From page 87 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 review, the licensee failed to ensure privacy was maintained for one of seven residents (R3) 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, 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).	02410			

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NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601		
(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
02410	Continued From page 88 The findings include: R3's diagnoses included Parkinson's disease. R3's Service Plan dated April 1, 2025, noted R3 received services including assistance with ambulation, bathing, dressing, and medication administration. R3's prescriber orders dated March 7, 2025, included: - Exelon patch 13.3 milligrams (mg)/24 hour patch topical. Apply daily and remove old patch. On April 23, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F administer R3's medications to her in the dining room, where multiple residents were sitting at tables waiting for breakfast. After administering the oral medications, LPN-F pulled R3's shirt down and out in the back, removed a patch from the right upper back, and placed the new Exelon patch on the upper right back. LPN-F then returned R3's shirt to normal and left the area. Upon returning to the medication cart in the adjoining room, LPN-F stated it was easier to do the patch when she [R3] is out because she is always out in common areas. On April 23, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated staff should be returning the residents to their room to perform procedures such as placing a topical patch. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
(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
02480	Continued From page 89	02480			
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a process in place to respond to and resolve resident grievances. 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: During the entrance conference on April 21, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated the complaint procedure was that residents could write down their complaints, but usually just report verbally to her. CNS-A stated sometimes it is resolved right then and there and never gets documented. In addition, CNS-A stated there were no complaints documented for the last six months, and she did not have a process to document the complaints at this time. CNS-A also stated she has found there is a process to use in	02480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER GOLDPINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 30TH STREET NW BEMIDJI, MN 56601			
(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
02480	Continued From page 90 their electronic record system, but it has not been implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480			



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

Type: Full
Date: 04/24/25
Time: 11:28:28
Report: 3822251056

Food and Beverage Establishment Inspection Report

Page 1

Location:

Goldpine Home
1700 30th Street Northwest
Bemidji, MN56601
Beltrami County, 04

Establishment Info:

ID #: 0013159
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

GPH Beltrami Inc.

Phone #: 2184444346
ID #: 36551

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: KITCHEN WIPING BUCKET
Violation Issued: No

Chlorine: = 75 PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location: MILK COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location: ALL REACH-IN COOLERS
Violation Issued: No

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

INSPECTION FOR HRD.

WIPE DOWN SALT AND PEPPER SHAKERS ON DINING ROOM TABLES AFTER EACH USE.

SERVE LIQUID PASTEURIZED EGGS. FOOD FULLY COOKED.

Type: Full
Date: 04/24/25
Time: 11:28:28
Report: 3822251056
Goldpine Home

Food and Beverage Establishment Inspection Report

Page 2

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 3822251056 of 04/24/25.

Certified Food Protection Manager Mike Davis

Certification Number: FM45752 Expires: 08/06/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Mike Davis
Head Cook

Signed: _____



Dave Kaufman, RS
Environmental Health Specialist
Bemidji District Office
218-308-2100
david.kaufman@state.mn.us