DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 12, 2023

Licensee
Golden Manor Of Barnesville
1102 4th Avenue Northeast
Barnesville, MN 56514

RE: Project Number(s) SL21407015

Dear Licensee:

On May 8, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 29, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

April 14, 2023

Licensee
Golden Manor of Barnesville
1102 4th Avenue Northeast
Barnesville, MN 56514

RE: Project Number(s) SL21407015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an evaluation on March 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance withMinn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21407	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR OF BARNESVILLE	1102 4TH AVENUE NE BARNESVILLE, MN 56514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21407015-0 On March 27, 2023, thru March 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 residents whom were receiving services under the Assisted Living Dementia Care license. An immediate correction order was identified on March 29, 2023, issued for SL21407015, tag identificaiton 2310. On March 29, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 2 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 3 (2) 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 observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C started employment on January 16, 2012, and began providing services under the assisted living with dementia license on August 1, 2021. On March 28, 2023, at 8:14 a.m., the evaluator observed ULP-C provide morning cares, including a shower to R1. ULP-C's employee records lacked the following required orientation content:	01470		

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01470	Continued From page 4 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On March 30, 2023, at 11:00 a.m., licensed assisted living director (LALD)-E stated he wasn't sure if the older employees received all of the assisted living requirement trainings, and would provide what he had for ULP-C. The licensee's Alzheimer's Disease and Related Disorders-Training and Notification policy dated August 1, 2021, noted required dementia training topics would include, person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=F	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	01500		

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01500	Continued From page 5 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 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 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 of all of the residents.) The findings include: ULP-C ULP-C started employment on January 16, 2012, and began providing services under the assisted living with dementia care license on August 1, 2021. On March 28, 2023, at 8:14 a.m., the evaluator observed ULP-C provide morning cares, including a shower to R1. ULP-D ULP-D started employment May 23, 2011, and began providing services under the assisted living with demenia care license on August 1, 2021. On March 28, 2023, at 7:30 a.m., the evaluator observed ULP-D administer scheduled morning medications to R5.	01500		

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01500	Continued From page 7 On March 30, 2023, at 11:00 a.m., licensed practical nurse/assistant housing director (LPN/AHD)-F stated the annual trainings are done monthly. Licensed assisted living director (LALD)-E stated he will provide what he has regarding annual training and all staff attendance was documented in the "Rtasks" computer program. ULP-C and ULP-D's employee training records lacked the number of hours received for annual training. In service monthly trainings documents "Mandatory In-Service Training Schedule Golden Manor Assisted Living, 2022 & 2023" indicated subjects, dates, and times, but no detail or length of each training. ULP-C and ULP-D's in service training record documentation in "RTasks" documented the date, instructor, and who participated, but no other information. The licensee's Orientation & Training policies dated August 1, 2021, indicated home health aid (HHA) annual policy and skills record will be used to ensure all regularly performed delegated assisted living tasks have been completed every 12 months, and a copy of the education, training and competency testing shall be kept in each staff personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 8 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans were revised to reflect the current services provided for one of one resident (R5). 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).	01640		

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01640	Continued From page 9 The findings include: R5's diagnoses included a cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), neutropenia (low count of white blood cells), and hypertension (high blood pressure). R5's Service Plan dated June 11, 2021, indicated R5 received services including assistance with medication, bathing, housekeeping, laundry, and meal reminders. R5's prescriber orders dated March 21, 2023, included an order for Neupogen 480 microgram (mcg)/1.6 milliliter(ml), bring 1 prefilled syringe and alcohol pad to resident. She will inject 0.55 ml (165 mcg) subcutaneous (sq) once daily. R5's March 2023 electronic medication administration record (EMAR) indicated scheduled Neupogen 480 mcg syringe, bring 1 prefilled syringe and alcohol pad to resident. She will inject 0.55 ml (165mcg) once daily. On March 28, 2023, at 8:52 a.m., unlicensed personnel (ULP)-D was observed to administer R5's scheduled Neupogen sq medication. ULP-D obtained a prefilled syringe of Neupogen [equivalent to 165 mcg] from the medication refrigerator and went to R5s room. ULP-D stated the nurses' setup R5's prefilled Neupogen syringes, and we (ULPs) administer it to her. R5 used to administer the injection, but it's too hard for her, we have been doing it for a while now. ULP-D was unsure of exactly when this changed. On March 29, 2023, at 11:00 a.m., clinical nurse	01640		

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01640	Continued From page 10 supervisor (CNS)-B and licensed assisted living director (LALD)-E stated the service plan was not up to date for R5. CNS-B stated the ULPs have been giving the Neupogen injections for a while and were trained to administer it, the service plan was just not updated yet. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan will be revised, if needed based on resident assessments and monitoring. The service plan and any revisions shall include a signature or other authentication by this community and by the resident, or resident's representative, documenting agreement on services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the clinical nurse supervisor nurse (CNS)-B completed a medication reassessment after a change of condition for one of three residents (R5).	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21407	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR OF BARNESVILLE	1102 4TH AVENUE NE BARNESVILLE, MN 56514

(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
01710	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 27, 2023, at 10:00 a.m., during entrance conference CNS-B stated comprehensive assessments were completed upon admission, at day 14, every 90 days and with any significant change in condition. R5's diagnoses included a cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), neutropenia (low count of white blood cells), and hypertension (high blood pressure). R5's Service Plan dated June 11, 2021, indicated R5 received services including assistance with medication, bathing, housekeeping, laundry, and meal reminders. R5's comprehensive nursing assessment dated January 1, 2023, indicated staff would bring R5 her daily injection of Neupogen for self-administration. On March 28, 2023, at 8:52 a.m., unlicensed personnel (ULP)-D was observed to administer R5's scheduled Neupogen medication. ULP-D obtained a prefilled syringe of Neupogen [equivalent to 165 mcg] from the medication	01710		

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01710	Continued From page 12 refrigerator and went to R5's room. ULP-D stated the nurses' setup R5's Neupogen syringes, and ULPs administer it. R5 used to administer the subcutaneous (sq) injection but can no longer do it herself. R5's record lacked a change of condition medication reassessment following R5's inability to administer Neupogen. On March 30, 2023, at 11:00 a.m., CNS-B stated R5 did not have a change in condition medication assessment completed when R5 was no longer able to self-administer her Neupogen daily. The licensee's policy Assessment, Monitoring and Reassessment - Schedule (s), dated August 1, 2021, indicated ongoing resident assessments and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01730 SS=D	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	01730		

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01730	Continued From page 13 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 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 maintian a current individualized medication management plan for one of one resident (R5).	01730		

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01730	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 27, 2023, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to residents. R5's diagnoses included a cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), neutropenia (low count of white blood cells), and hypertension (high blood pressure). R5's Service Plan dated June 11, 2021, indicated R5 received services including assistance with medication administration. R5's individual medication management plan dated January 1, 2023, indicated resident can self-administer Neupogen injection daily. Staff will obtain medication from locked medication fridge in medication room and bring to resident for self-injection. On March 28, 2023, at 8:52 a.m., unlicensed personnel (ULP)-D was observed to administer R5's scheduled Neupogen medication. ULP-D obtained a prefilled syringe of Neupogen [equivalent to 165 mcg] from the medication	01730		

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01730	Continued From page 15 refrigerator and went to R5's room. ULP-D stated the nurses' setup R5's Neupogen syringes, and ULPs administer it. R5 used to administer the subcutaneous (sq) injection but can no longer do it herself. R5's individual management plan was not updated to reflect her need for ULP assistance with Neupogen. On March 30, 2023, at 11:00 a.m., CNS-B stated R5 did not have a change in condition assessment completed when R5 was no longer able to self-administer her Neupogen daily. The licensee's policy Assessment, Monitoring and Reassessment - Schedule (s), dated August 1, 2021, indicated ongoing medication management, monitoring and assessments will be completed when the resident presents with symptoms or other issues that may be medication related. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	01770		

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01770	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R5). 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 March 27, 2023, 10:00 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services but did not provide medication set-ups. R5's diagnoses included a cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), neutropenia (low count of white blood cells), and hypertension (high blood pressure). R5's service plan dated June 11, 2021, indicated the resident received medication management services. R5's assessment dated January 1, 2023, indicated the resident required medication management, including help with an injectable medication. It noted the staff will bring the injection of Neupogen to her in the morning and she will safely administer herself.	01770		

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01770	Continued From page 17 R5's prescriber orders dated March 21, 2023, included an order for Neupogen 480 microgram (mcg)/1.6 milliliter(ml) vial, bring 1 prefilled syringe and alcohol pad to resident. She will inject 0.55 ml (165 mcg) sub cutaneous (sq)once daily. On March 27, 2023, at 12:03 p.m., during the entrance tour, evaluator observed five (5) syringes in the medication refrigerator. Labels on syringes included R5's name, Neupogen, 480 mcg, inject 1 syringe 0.55 ml (165mcg) sq daily. CNS-B stated the nurses set up the Neupogen syringes, R5 used to give herself the injection, but she is unable to do it herself anymore, so the unlicensed personnel (ULPs) were trained to administer it. On March 28, 2023, at 8:52 a.m., ULP-D was observed to administer R5's scheduled Neupogen medication. ULP-D obtained a prefilled syringe of Neupogen [equivalent to 165 mcg] from the medication refrigerator and went to R5s room. ULP-D stated the nurses' setup R5's prefilled Neupogen syringes, and ULPs administer it to her. R5 used to administer the sq injection, but it's too hard for her, we have been doing it for a while now. She was unsure of exactly when this changed. R5's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. On March 29, 2023, at 11:00 a.m.., CNS-B stated R5's medication setup for the Neupogen was not	01770		

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01770	Continued From page 18 documented in the resident's record to include the required content noted above. Licensed assisted living director (LALD)-E stated the licensee did not have a setup medication policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the expiration date for time sensitive medications 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 27, 2023, at 12:03 p.m., a tour of the	01890		

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01890	Continued From page 19 medication room was conducted with clinical nurse supervisor (CNS)-B, including a review of the medication cart. On March 27, 2023, at 12:05 p.m., the evaluator observed R1's opened Lantus100 units/milliliter (ml) and Humalog 100 units/ml insulin pens (a multiple dose pen shaped injector device for insulin administration) inside the medication cart. Lantus had opened date, but no expiration date. Humalog had no open or expiration date. CNS-B stated the insulins should be marked with an open and expiration dates. The manufacturer's instructions for Lantus insulin pens dated June 2022, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Humalog insulin pens dated April 2020, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Storage of Medications policy dated August 1, 2021, indicated, once opened, medications need to be labeled and dated with the open date, and expirations date, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	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 20 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 provide care and services according to acceptable health care, medical, or nursing standards of one of three resident (R2) with consumer bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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). This resulted in an immediate correction order on March 29, 2023. The findings include: R2's diagnoses included hypertension (high blood pressure) and transient ischemic attack (brief stroke). R2's service plan dated June 24, 2022, indicated the resident received services which included medication administration, housekeeping, laundry, assistance with colostomy and dressing. On March 28, 2023, at 11:25 a.m., evaluator and clinical nurse supervisor (CNS)-B observed a consumer bedrail on the right side of R2's bed. CNS-B stated she was not aware R2 had a	02310		

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02310	Continued From page 21 consumer bedrail. A shepard hook bedrail was attached to piece of wood (20 inch x 24 inch by 1 inch thick, (approximate deminsions)) which fit between boxspring and matress and was secured to bed with a strap. R2 stated he has the rail for a long time and a previous nurse had put it on his bed. R2 stated the rail assists him repositioning in bed and transferring from the bed. CNS-B stated she was aware a bedrail assessment needs to be completed on any bedrails. R2's Assessment dated December 30, 2022, did not include an assessment for the consumer bedrail to include: -purpose or intent of the bedrail, -condition or description of bedrail, -individualized risk versus benefits discussion, -installation and manufacturer guidelines information and, -physical inspection of bedrail and mattress for areas of entrapment. The licensee's policy, Mobility Bar (Grab Bar, Halo Bar, Side Rail and Bedsile Rail) dated August 1, 2021, indicated when a mobility bar(s) are in use, the registered nurse (RN) shall conduct an assessment to identify the intended purpose of the device and the risks regarding the use of the device. The FDA, "Adult Portable Bed Rail Safety " revised February 27, 2023, included the following information: " 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.	02310		

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02310	Continued From page 22 Historically, physical restraints (such as vests, ankle, or wrist restraints) were used to try to keep patients safe in health care facilities. In recent years, the health care community has recognized that physically restraining patients can be dangerous. Although not indicated for this use, bed rails are sometimes used as restraints. Regulatory agencies, health care organizations, product manufacturers and advocacy groups encourage hospitals, nursing homes and home care providers to assess patients' needs and to provide safe care without restraints." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluator's on-site observtions and review by evaluation supervisor on March 29, 2023, however, non-compliance remains at a scope and level of three, isolated (G).	02310		

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

Type: Full
Date: *03/28/23*
Time: 11:00:56
Report: 1034231064

Food and Beverage Establishment Inspection Report

Location:
Golden Manor Of Barnesville
1102 4th Avenue Ne
Barnesville, MN56514
Clay County, 14

Establishment Info:
ID #: 0037804
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183547200
ID #:

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

The following orders were issued during this inspection.

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

3-304.15A ** Priority 1 **

MN Rule 4626.0287A Single-use gloves must be used for only one task and be discarded when damaged or soiled, or when interruptions occur in the operation.

FOOD EMPLOYEE USED PHONE WHILE WEARING GLOVES AND DID NOT CHANGE GLOVES AFTER.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

ACCORDING TO SPEC SHEET, DISHWASHER CAN ONLY ACHIEVE A UTENSIL SURFACE TEMP OF 156 DEGREES F. REPLACE DISHWASHER WITH ONE THAT ACHIEVE A UTENSIL SURFACE TEMP OF 160 DEGREES F OR HIGHER, OR ONE THAT USES CHEMICALS.

Comply By: 04/04/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NEED THERMOMETER OR DISHWASHER TEMPERATURE STRIPS.

Comply By: 04/04/23

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST MOLLY'S CERTIFICATE.

Comply By: 04/11/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40.3 Degrees Fahrenheit - Location: Juice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40.2 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30.0 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 31.2 Degrees Fahrenheit - Location: Milk
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1034231064 of 03/28/23.

Certified Food Protection Manager: Molly Norman

Certification Number: FM110528 Expires: 04/01/25

Inspection report reviewed with person in charge and emailed.

Signed: emailed
Establishment Representative

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