



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 27, 2024

Licensee
Golden Pond WBL
4624 Stoddart Circle
Saint Paul, MN 55127

RE: Project Number(s) SL32589015

Dear Licensee:

On June 3, 2024, 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 March 12, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 12, 2024 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 March 12, 2024, found not corrected at the time of the June 3, 2024, follow-up survey and/or subject to penalty assessment are as follows:

- 0660 - Tuberculosis Prevention And Control - 144g.42 Subd. 9**
- 0950 - Designation Of Representative - 144g.50 Subd. 3**
- 1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E)**
- 1880 - Storage Of Medications - 144g.71 Subd. 19 - \$500.00**
- 1940 - Individualized Treatment Or Therapy Managemen - 144g.72 Subd. 3**

The details of the violations noted at the time of this follow-up survey completed on June 3, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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 Jodi Johnson at 507-344-2730.

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, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN POND WBL			STREET ADDRESS, CITY, STATE, ZIP CODE 4624 STODDART CIRCLE SAINT PAUL, MN 55127		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32589015-1 On June 3, 2024, 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 March 12, 2024. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued: 0660, 0950, 1640, 1880, and 1940.	{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.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 660}	Continued From page 1 (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 maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of three employees (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 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:	{0 660}			

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{0 660}	Continued From page 2 ULP-H was hired November 29, 2023, to provide direct care and services to the facility's residents. ULP-H's employee record contained a negative one step tuberculin skin test (TST) dated March 16, 2024; however, ULP-H's employee record lacked evidence of the following: - second step TST On June 3, 2024, at 10:48 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-H's employee record was missing a second step TST. The licensee's Tuberculosis Screening policy, undated, indicated all staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool. No further information was provided.	{0 660}			
{0 780} SS=F	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	{0 780}			

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{0 780}	Continued From page 3 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; This MN Requirement is not met as evidenced by: No further action needed.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action needed.	{0 790}			

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{0 800}	Continued From page 4	{0 800}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action needed.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall 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.	{0 810}			

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{0 810}	Continued From page 5 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed.	{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	{0 950}			

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{0 950}	Continued From page 6 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 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 offer the resident the opportunity to identify a designated representative in writing with the required statutory language. This had the potential to affect all residents. 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 the potential to affect a large portion or all the residents). The findings include: R1 R1 admitted to licensee and began receiving assisted living services on December 1, 2018. R1's Residential Care Agreement contract dated March 18, 2024, indicated R1 declined to provide a designated representative. However, the acknowledgement of receiving the "Copy of Resident's Right to Designate a Representative	{0 950}			

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{0 950}	Continued From page 7 for Certain Purposes" notice was left blank. R2 R2 admitted to licensee and began receiving assisted living services on November 20, 2020. R2's Residential Care Agreement contract dated February 15, 2024, did not list a designated representative, and the box to initial, if a resident declined to name a designated representative, was left blank. In addition, the acknowledgment of receiving the "Copy of Resident's Right to Designate a Representative for Certain Purposes" notice was left blank. On June 3, 2024, at 11:46 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the reason R1 and R2's acknowledgement of receiving the "Copy of Resident's Right to Designate a Representative for Certain Purposes" notice was left blank was because the licensee did not have a separate document that included the verbatim "right to designate a representative for certain purposes" notice. LALD/CNS-A further stated she thought by giving each resident the Assisted Living Bill of Rights meant she did not need the separate document that included the verbatim "right to designate a representative for certain purposes: notice. Furthermore, LALD/CNS-A stated R2's record lacked documentation to designate or decline a representative. The licensee's 1.08 Designated Representative policy dated August 1, 2021, indicated the designated representative form must provide the following verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	{0 950}			

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{0 950}	Continued From page 8 "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." No further information was provided.	{0 950}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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	{01640}			

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{01640}	Continued From page 9 by: Based on interview and record review, the licensee failed to ensure a signed written service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on November 20, 2020, with diagnoses that included myocardial infarction (a blockage of blood flow to the heart muscle, also known as a heart attack) and aphasia (a language disorder that affects a person's ability to communicate). R2's service plan dated April 2, 2024, indicated R2 received assistance with AM cares, grooming, dressing, continence care, toileting, bathing, ambulation/exercise, escort/mobility assistance, behavior management, activity assistance, meal assistance and medication management. R2's service plan was not signed by R2 or R2's legal representative. On June 3, 2024, at 12:08 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2's service plan was emailed to R2's legal representative but it had not been returned.	{01640}			

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{01640}	Continued From page 10 The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions would include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01640}			
{01880} SS=F	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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 3, 2024, at approximately 9:15 a.m.	{01880}			

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{01880}	Continued From page 11 during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had corrected the medication storage citation by adding a padlock to the medication cabinet. -at 9:22 a.m., the surveyor observed unlicensed personnel (ULP)-E remove a bottle of Miralax from an unlocked medication cabinet to administer to R2. ULP-E brought the medication to R2's room, leaving the medication cabinet unlocked and unattended. - at 1:56 p.m., LALD/CNS-A stated she had put padlock on the main medication cabinet but not the second cabinet that also stored resident medications. No further information provided.	{01880}			
{01940} SS=E	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	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN POND WBL		STREET ADDRESS, CITY, STATE, ZIP CODE 4624 STODDART CIRCLE SAINT PAUL, MN 55127			
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{01940}	Continued From page 12 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 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R1 R1 diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 20, 2024,	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 13 indicated R1 received assistance with range of motion exercises (ROM) and blood sugar checks. R1's physician orders dated November 14, 2023, indicated blood sugar checks every other day and daily ROM exercises. R1's records lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2 was admitted on November 20, 2020, with diagnoses that included myocardial infarction (a blockage of blood flow to the heart muscle, also known as a heart attack) and aphasia (a language disorder that affects a person's ability to communicate). R2's unsigned service plan dated April 2, 2024, indicated R2 received assistance with ambulation/exercise with ROM on odd days. R2's physician orders dated November 14, 2023, indicated ambulation/exercise with ROM on odd	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 days. R2's records lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 3, 2024, at 12:02 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2's records lacked a treatment management plan to include all the required content as noted above. LALD/CNS-A further stated she thought she updated R1's treatment plan after the initial survey and did not know why it was not showing up in the electronic health record (EHR). -at 12:31 p.m., LALD/CNS-A stated she called the help desk for the licensee's EHR and found out they were not selecting the correct options to carry over services to be listed under a treatment management plan. The licensee's Individualized Treatment or Therapy Management Plan policy dated December 27, 2023, indicated the licensee would develop and maintain a current individualized	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 15 treatment and therapy management record for each resident which would include at least the following: - a statement of the type of services that would be provided; - document of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy 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. No further information was provided.	{01940}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 5, 2024

Licensee
Golden Pond WBL
4624 Stoddart Circle
Saint Paul, MN 55127

RE: Project Number(s) SL32589015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 2024, 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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 with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: jodi.johnson@state.mn.us Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32589015 On March 11, 2024, through March 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. 1290: An immediate order was identified on March 11, 2024. The immediacy was lifted on March 12, 2024; however, non-compliance remained at a level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the	0 130			

Minnesota Department of Health

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0 130	Continued From page 2 licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201;	0 130			

Minnesota Department of Health

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0 130	Continued From page 3 (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership,	0 130			

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0 130	Continued From page 4 or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals (unlicensed personnel (ULP)-E and ULP-H) residing at the facility. 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 the residents). The findings include: The licensee's assisted living licensure effective date was June 1, 2023, with an expiration date of May 31, 2024. On March 11, 2024, at 10:00 a.m. during the facility tour with registered nurse (RN)-B, the surveyor was shown the "staff quarters" in the lower level. This consisted of two bedrooms, a bathroom, and a living room. ULP-E was staying in one of the rooms and ULP-H was sleeping in the second room. RN-B stated most of their staff didn't drive and so they were allowed to stay and sleep if they didn't have a ride or if they worked multiple days in a row. RN-B further stated most	0 130			

Minnesota Department of Health

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0 130	Continued From page 5 days of the week one or more ULP are staying in the staff quarters. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 5. Assisted living contract-"Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility- "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. -"Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health,	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation	0 250			

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0 250	Continued From page 7 by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. 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 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 March 11, 2024, at 9:45 a.m., registered nurse (RN)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section]	0 250			

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0 250	Continued From page 8 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult	0 250			

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0 250	Continued From page 9 Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - 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. - 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. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by the	0 250			

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0 250	Continued From page 10 licensee's agent on April 7, 2023. The licensee had an assisted living license issued on June 1, 2023, with an expiration date of May 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) 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; (5) infection control practices; (6) 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; and (7) medication and treatment management As a result of this survey, the following orders were issued 0510, 0550, 0660, 1370, 1380, 1470, 1620, 1880, 1940, and 1970 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	0 250			

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0 250	Continued From page 11	0 250			
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 by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet	0 470			

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0 470	Continued From page 12 the needs of all residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held and assisted living license. The facility was licensed for a capacity of four and had a current census of four residents. During the entrance conference on March 11, 2024, at 9:45 a.m., registered nurse (RN)-B stated the licensee had not developed a staffing plan. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	0 480			

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0 480	Continued From page 13 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 11, 2024, for the specific Minnesota Food code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the 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	0 510			

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0 510	Continued From page 14 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control for one of two employees (house coordinator/unlicensed personnel (HC/ULP)-G) 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). The findings include: R1 was admitted on December 1, 2018, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 1, 2024, indicated R1 received assistance with medication management. On March 12, 2024, at 7:56 a.m., the surveyor observed HC/ULP-G prepare and administer medications to R1. While administering R1's medications, one pill fell onto the floor. HC/ULP-G picked the pill up from the floor and administered it to R1.	0 510			

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0 510	Continued From page 15 On March 12, 2024, at 9:00 a.m., registered nurse (RN)-B stated HC/ULP-G should not have administered the pill that fell onto the floor. RN-B stated she would expect the ULP to notify a nurse regarding the pill and replace it with a new one to administer. No further information 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	0 550			

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0 550	Continued From page 16 licensee'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 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 March 11, 2024, at 10:00 a.m. during the facility tour with registered nurse (RN)-B, the surveyor observed the licensee's grievance policy posted by the front door of the facility. Though the posted grievance policy included the name and phone number of the individual who was responsible for handling resident grievances, it did not include the individual's email. In addition, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD), and Minnesota Adult Abuse Reporting Center (MAARC) was missing. On March 11, 2024, at 3:01 p.m. RN-B reviewed the posted grievance policy and stated it lacked the above content as required. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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0 660	Continued From page 17	0 660			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-F). In addition, the licensee failed to complete a facility tuberculosis (TB) risk assessment. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660			

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0 660	Continued From page 18 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, March 11, 2024, at 1:45 p.m., registered nurse (RN)-B provided a facility TB risk assessment dated October 12, 2021, but it was for a different facility. ULP-F was hired August 1, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record contained a TB history and symptom screening dated October 18, 2023, ULP-F's record lacked evidence of a two-step TST. On March 11, 2024, at 11:30 a.m. RN-B stated ULP-F's employee record was missing the above listed content. LALD/RN-A further stated the current facility TB risk assessment was for a different facility. The licensee's Tuberculosis Screening policy, undated, indicated the licensee would maintain a current community TB risk assessment. It further indicated all staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 19	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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 20 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following: - establish and maintain a comprehensive EPP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - community risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures	0 680			

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0 680	Continued From page 21 and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - entities providing services under agreement; - residents' physicians;	0 680			

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0 680	Continued From page 22 - volunteers; - communication plan must include contact information for: - other sources of assistance; - communication plan must include: - means to provide information about facility occupancy; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include a method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On March 12, 2024, at 9:03 a.m., registered nurse (RN)-B stated the licensee's current EP plan did not include the above content. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated June 1, 2021, indicated the licensee would have an EPP in writing that would include all required elements of appendix Z, reviewed annually, and is based on the licensee's facility and community risk assessments utilizing an all-hazards approach. No additional information was provided.	0 680			

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0 680	Continued From page 23	0 680			
0 780 SS=F	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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.	0 780			

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0 780	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 2:00 p.m., survey staff toured the home with house coordinator/unlicensed personnel (HC/ULP)-C. During the tour, survey staff observed there was not a smoke alarm installed outside resident bedrooms one and two. The distance to the nearest smoke alarm from bedroom one measured twenty-five feet. The distance to the nearest smoke alarm from bedroom two measured twenty-four feet. A smoke alarm was not installed outside this sleeping area in the immediate vicinity of bedrooms. During the facility tour interview, on March 11, 2024, HC/ULP-C verified a smoke alarm was not installed outside bedrooms one and two. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790			

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0 790	Continued From page 25 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain portable fire extinguishers as required by statute. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 2:00 p.m., survey staff toured the home with house coordinator/unlicensed personnel (HC/ULP)-C. During the tour, survey staff observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. 2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire	0 790			

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0 790	Continued From page 26 extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 3. The fire extinguisher installed inside a kitchen cabinet was sized 3 pounds 7oz. Fire extinguishers must have a minimum 2-A:10-B:C rating. 4. The fire extinguisher installed in the living on the wall was obstructed by a couch positioned in front of it. Fire extinguishers must be readily available in the event of an emergency. During an interview on March 12, 2024, at 3:00 p.m., registered nurse (RN)-B verified the fire extinguishers had not received annual maintenance and monthly inspections. RN-B verified the fire extinguisher in the kitchen did not meet the rating requirements and that the couch in the living room needed to be relocated. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800			

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0 800	Continued From page 27 by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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). The findings include: On March 11, 2024, at 2:00 p.m., survey staff toured the home with house coordinator/unlicensed personnel (HC/ULP)-C. During the tour, survey staff observed the following: 1. The interior door leading into the attached garage from the home was inappropriately designed as an exit on the emergency floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During an interview on March 12, 2024, at 3:00 p.m., registered nurse (RN)-B verified the door leading into the garage was designated as an exit and stated this required revision. 2. Sliding bolt locks were improperly installed near the top of two doors designated as exits on the emergency floor plan in these locations: a. The interior dining room door leading out to the deck. b. The interior door leading into the attached	0 800			

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0 800	Continued From page 28 garage from the home. Sliding bolt locks are not permitted on exit doors. Door latching hardware is required to be located not higher than 48" from the floor. Egress doors must release from the latched position in one operation. During an interview on March 12, 2024, at 3:00 p.m., registered nurse (RN)-B verified these sliding bolt locks required removal. 3. The paths for egress escape were obstructed in these locations: a. An exit sign was posted above the dining room door. A table and chairs were located in front of this door. b. In occupied resident bedroom one, a table and chairs were located in front of the egress window. c. In occupied resident bedroom two, furniture was positioned in front of a door designated as an exit on the emergency floor plan. Improper placement of furniture could delay exiting in the event of an emergency. All paths of egress must provide unobstructed exiting. During an interview on March 12, 2024, at 3:00 p.m., registered nurse (RN)-B verified these exit paths were obstructed. 4. In basement bedroom six, handles were not installed on either of the two windows which were designated as exits on the emergency floor plan. Egress window hardware must be properly maintained. Missing egress window handles would delay exiting in the event of an emergency. HC/ULP-C verified the window handles were missing and stated this was an employee bedroom which was not used by residents. Additionally, a plastic crossbar held in place by brackets was installed in front of both windows in this bedroom. HC/ULP-C verified this crossbar obstructed the egress window and it was removed during the facility tour.	0 800			

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0 800	Continued From page 29	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 30 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. 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 potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a fire safety policy dated June 1, 2021. This policy was a template and had not been developed for use at this facility. The FSEP fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The policy inappropriately referenced smoke compartment doors, fire sprinklers, and doors on magnetic holders. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP fire safety policy failed to include specific fire protection procedures for residents evident by limited instructions directing employees to remove tenants from immediate	0 810			

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0 810	Continued From page 31 danger by evacuating those closest to the fire. No additional fire protection procedures necessary for residents were included. The FSEP fire safety policy directs employees to evacuate residents from the building but failed to include information on where residents should relocate to in the event of a fire. During an interview on March 12, 2024, at 3:00 p.m., registered nurse (RN)-B verified the FSEP included inaccurate information and lacked detailed procedures. RN-B explained residents would relocate to the cul-du-sac in front of the house in the event of an evacuation and verified this was not included in the plan. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. During an interview with survey staff on March 12, 2024, at 3:00 p.m., RN-B verified training records were not available to support FSEP training had been completed and explained employees were trained on the FSEP during evacuation drills. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. During an interview with survey staff on March 12, 2024, at 3:00 p.m., RN-B verified resident training records were not available and explained resident names were listed on the evacuation drill records when they participated. RN-B further explained all the residents participated in the February 2024 evacuation drill and their names were recorded on this drill log. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill	0 810			

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0 810	Continued From page 32 every other month as evident by emergency evacuation drill reports lacking the required frequency. Six drill reports were documented in 2022. Six drill reports were documented in 2023. All of these drills were completed between 1:00 p.m. and 4:00 p.m. Employee evacuation drills were not completed twice per year during the night shift. During an interview with survey staff on March 12, 2024, at 3:00 p.m., RN-B verified drills had not been performed during the night shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900			

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0 900	Continued From page 33 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content 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: R1 was admitted on December 1, 2018, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's record lacked a written contract. On March 11, 2024, at 1:28 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 was issued a new contract in 2021, when the licensee changed to	0 900			

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0 900	Continued From page 34 an assisted living licensee. On March 12, 2024, at 8:05 a.m., house coordinator/unlicensed personnel (HC/ULP)-G stated R1 did not have an updated contract. HC/ULP-G further stated R1's daughter had been emailed the contract to review and sign but had not returned it yet. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated a contract would be signed by the resident and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
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	0 950			

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0 950	Continued From page 35 ("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 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 offer the resident the opportunity to identify a designated representative in writing with the required statutory language. This had the potential to affect all residents. 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 the potential to affect a large portion or all the residents). The findings include: R1 admitted to licensee and began receiving assisted living services on December 1, 2018. R1's record lacked evidence of an assisted living contract. The surveyor reviewed a blank Assisted Living Contract, and it lacked documentation of an	0 950			

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0 950	Continued From page 36 opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On March 12, 2024, at 9:20 a.m., house coordinator/unlicensed personnel (HC/ULP)-G stated the same contract was used for all residents and it lacked documentation of an opportunity to designate a representative and the verbatim "right to designate a representative for certain purposed" notice. The licensee's 1.08 Designated Representative policy dated August 1, 2021, indicated the designated representative form must provide the following 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290			

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01290	Continued From page 37 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility. This resulted in an immediate correction order on March 11, 2024. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on January 20, 2017, and began providing assisted living services for the license on August 1, 2021.	01290			

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01290	Continued From page 38 ULP-E's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license. On March 11, 2024, at 1:28 p.m. a review of NETStudy showed that ULP-E was not affiliated with assisted living facility HFID 32589. On March 11, 2024, at 2:13 p.m. licensed assisted living director (LALD)-A stated via email "I know for sure that I did all the background studies on our staff." LALD-A further stated she believed it was some sort of "computer glitch maybe or something" as the reason for not having a background study for ULP-E. The licensee's monthly schedule dated March 2024, indicated ULP-E had worked unsupervised on March 2, 2024, March 3, 2024, March 5, 2024, March 6, 2024, and March 10, 2024. On March 11, 2024, at 1:45 p.m. registered nurse (RN)-B stated the licensee's secretary emailed her indicating ULP-E's background study was not completed, but they would submit one today. The licensee's Background Studies policy dated August 1, 2021, indicated no employee would provide direct services and have independent contact with any residents until acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 12, 2024, the immediacy for correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290			

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01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (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	01370			

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01370	Continued From page 40 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 was completed for two of three employees (unlicensed personnel (ULP)-D and ULP-F) to include all required content. 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-D ULP-D was hired on November 29, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them	01370			

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01370	Continued From page 41 ULP-F ULP-F was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting -standby assistance techniques and how to perform them On March 11, 2024, at 11:52 a.m., registered nurse (RN)-B stated ULP-D and ULP-F were trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULP would include the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380 SS=E	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 was completed for two of three employees (unlicensed personnel (ULP)-D and ULP-F) to include all required content. 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:	01380			

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01380	Continued From page 43 ULP-D ULP-D was hired on November 29, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required ULP-F ULP-F was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record lacked evidence of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required On March 11, 2024, at 11:52 a.m., registered nurse (RN)-B stated ULP-D and ULP-F were trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULP would include the following: - reading and recording temperature, pulse, and respirations of the resident	01380			

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01380	Continued From page 44 - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff 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	01470			

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01470	Continued From page 45 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated 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 one of three employees (unlicensed personnel (ULP)-D) received orientation to assisted living facility licensing requirements and regulations before providing services. 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	01470			

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01470	Continued From page 46 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-D was hired on November 29, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On March 11, 2024, at 11:50 a.m., registered nurse (RN)-B stated ULP-D had not completed all components of the required orientation training for assisted living facilities. The licensee's 5.01 Orientation of Staff and Supervisors policy dated August 1, 2021, indicated all employees would complete orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530			

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01530	Continued From page 47 (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 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 interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-F) 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	01530			

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01530	Continued From page 48 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: The licensee provided services under an Assisted Living license. ULP-F was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record contained evidence the employee received 2.5 hours of dementia care training, and not the required eight hours of training within 160 working hours of the employment start date. On March 11, 2024, at 11:48 a.m., registered nurse (RN)-B stated ULP-F's record lacked the required amount of training in dementia care. RN-B further stated ULP-F was a rehire and she thought she did not need the full eight hours of dementia training due to completing them when she previously worked for the licensee. The licensee's 5.03 Dementia Training policy dated August 1, 2023, indicated employees would complete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN POND WBL		STREET ADDRESS, CITY, STATE, ZIP CODE 4624 STODDART CIRCLE SAINT PAUL, MN 55127			
(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
01620	Continued From page 49 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment 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 the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days 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	01620			

Minnesota Department of Health

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01620	Continued From page 50 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on December 1, 2018, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 1, 2024, indicated R1 received assistance with grooming, dressing, bathing, toileting, transfers, mobility, range of motion exercises, behavior management, meal assistance, blood sugar checks and medication management. R1's ongoing nursing assessments were requested. Assessments dated February 13, 2023, May 28, 2023, and December 23, 2023, were provided. The May 28, 2023, assessment was done 104 days after the date of the previous assessment, exceeding 90 calendar days. The December 23, 2023, assessment was done 214 days after the date of the previous assessment, exceeding 90 calendar days. On March 11, 2024, at 12:31 p.m. RN-B stated R1's May and December assessments exceeded 90 days from the previous assessment. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and could	01620			

Minnesota Department of Health

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01620	Continued From page 51 not exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 interview and record review, the licensee failed to ensure a signed written service plan was revised to reflect the current services	01640			

Minnesota Department of Health

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01640	Continued From page 52 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: R1 was admitted on December 1, 2018, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 1, 2024, indicated R1 received assistance with grooming, dressing, bathing, toileting, transfers, mobility, range of motion exercises, behavior management, meal assistance, blood sugar checks and medication management. The service plan did not include oxygen services. R1's service plan was not signed by the licensee. On March 12, 2024, at 8:12 a.m., registered nurse (RN)-B stated R1's service plan did not include oxygen services and had not been signed by the licensee. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions would include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be	01640			

Minnesota Department of Health

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01640	Continued From page 53 provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01880 SS=F	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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 10:00 a.m. during the facility tour with registered nurse (RN)-B, the surveyor was shown multiple cabinets in the kitchen where all residents' medications were stored. RN-B opened the unlocked cabinets to	01880			

Minnesota Department of Health

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01880	Continued From page 54 show the surveyor the medications. Inside the medication cabinet was an unlocked tackle box where narcotics were stored. At this time, RN-B stated the tackle box with narcotics should be locked. On March 12, 2024, at 7:49 a.m., the surveyor observed house coordinator/unlicensed personnel (HC/ULP)-G remove R1's medications from the unlocked medication cabinets in the kitchen to prepare them for administration. HC/ULP-G administered R1's medications and then left the kitchen to assist another resident, leaving the medication cabinets unsecured and unattended. -at 8:10 a.m., HC/ULP-G stated they had a chain with a lock that they sometimes used but most of the time, the medication cabinets were left unlocked. -at 8:12 a.m., RN-B stated they kept the narcotic box locked but did not know the main medications cabinets needed to be locked when not in use. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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	01940			

Minnesota Department of Health

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01940	Continued From page 55 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 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content 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	01940			

Minnesota Department of Health

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01940	Continued From page 56 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 11, 2024, at 9:45 a.m., registered nurse (RN)-B stated the licensee provided treatment management services to their residents. The licensee's Current Client Roster dated March 11, 2024, indicated R1 had blood sugar checks, oxygen, and other treatments. R1 diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 1, 2024, indicated R1 received assistance with range of motion exercises (ROM) and blood sugar checks. The service plan lacked the service of oxygen management. R1's physician orders dated November 14, 2023, indicated blood sugar checks every other day and daily ROM exercises. R1's physician orders did not include orders for oxygen. R1's records lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy	01940			

Minnesota Department of Health

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01940	Continued From page 57 services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 11, 2024, at 3:06 p.m., registered nurse (RN)-B stated R1's record lacked a treatment management plan to include all the required content as noted above. RN-B stated R1's oxygen was to be used as needed (PRN) but could not locate the physician orders for oxygen. RN-B further stated she did not know when or how often R1 had used the PRN oxygen because the order had not been transcribed into R1's record for staff to document use. The licensee's Individualized Treatment or Therapy Management Plan policy dated December 27, 2023, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which would include at least the following: - a statement of the type of services that would be provided; - document of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was	01940			

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01940	Continued From page 58 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. 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	01970			

Minnesota Department of Health

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01970	Continued From page 59 situation has occurred only occasionally). The findings include: During the entrance conference on March 11, 2024, at 9:45 a.m., registered nurse (RN)-B stated the licensee provided treatment management services to their residents. The licensee's Current Client Roster dated March 11, 2024, indicated R1 had blood sugar checks, oxygen, and other treatments. R1 diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes. R1's service plan dated March 1, 2024, indicated R1 received assistance with range of motion exercises (ROM) and blood sugar checks. The service plan lacked the service of oxygen management. R1's physician orders dated November 14, 2023, indicated blood sugar checks every other day and daily ROM exercises. R1's record lacked physician orders for oxygen. On March 11, 2024, at 3:06 p.m., registered nurse (RN)-B stated R1's oxygen was to be used as needed (PRN) but could not locate the physician orders for oxygen. RN-B further stated she did not know when or how often R1 had used the PRN oxygen because the order had not been transcribed into R1's record for staff to document use. No further information was provided.	01970			

Minnesota Department of Health

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01970	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

Type: Full
Date: 03/11/24
Time: 11:00:00
Report: 1031241069

Food and Beverage Establishment Inspection Report

Page 1

Location:

Golden Pond Wbl
4624 Stoddart Circle
St Paul, MN55127
Ramsey County, 62

Establishment Info:

ID #: 0037518
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514260479
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

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

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT.
PRINT AND KEEP ILLNESS LOG ON SITE AND UP TO DATE.

Comply By: 03/11/24

3-800 Highly Susceptible Populations

3-801.11B

**** Priority 1 ****

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

EGGS BEING SERVED UNDERCOOKED. ESTABLISHMENT AGREED TO STOP PRACTICE UNTIL PASTEURIZED EGGS ARE AVAILABLE.

Comply By: 03/11/24

4-300 Equipment Numbers and Capacities

4-302.12B

**** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 03/14/24

Type: Full
Date: 03/11/24
Time: 11:00:00
Report: 1031241069
Golden Pond Wbl

Food and Beverage Establishment Inspection Report

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.
ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS.
PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 03/14/24

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 03/14/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).

Comply By: 03/11/24

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
ALL CUPBOARD HANDLES HAVE BLACK SEDIMENT THAT CAN BE SCRAPPED OFF WITH FINGERNAIL. REMOVE ALL HANDLES AND CLEAN (REMOVE ALL BLACK) OR REPLACE ALL HANDLES.

Comply By: 04/01/24

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.
OBSERVED WATER UNDER KITCHEN SINK SUGGESTING PLUMBING LEAK. FIND LEAK AND REPAIR. CLEAN AREA UNDER SINK.

Comply By: 04/01/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Chlorx Wipes
Violation Issued: No

Type: Full
Date: 03/11/24
Time: 11:00:00
Report: 1031241069
Golden Pond Wbl

Food and Beverage Establishment Inspection Report

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Mixed Greens
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cooking/Veg
Temperature: 177 Degrees Fahrenheit - Location: Pan in Stove
Violation Issued: No

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

Inspection conducted by Chris F.

All violations discussed with Ely during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.
- Extra care needs to be taken when cleaning behind cabinet hardware so debris does not build up.
- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.
- Keep tools and office supplies separate from food and cookware.
- When preparing food from raw, make sure to use a thermometer to check cooked temperatures.

Type: Full
Date: 03/11/24
Time: 11:00:00
Report: 1031241069
Golden Pond Wbl

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031241069 of 03/11/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ely Bulac
Person in Charge

Signed:_____ 
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031241069

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

3

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

03/11/24

Time In

11:00:00

Time Out

Golden Pond Wbl

Address

4624 Stoddart Circle

City/State

St Paul, MN

Zip Code

55127

Telephone

6514260479

License/Permit #

0037518

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

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

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

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

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

X

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

X

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

X

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 03/11/24

Inspector (Signature)