



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2022

Administrator
Golden Hearts Inc
602 Marion Drive
Arlington, MN 55307

RE: Project Number SL38174015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on May 26, 2022, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general
reconsideration requests to:

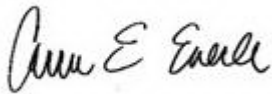
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration
requests should addressed to:

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

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

Sincerely,



Carrie Euerle, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: carrie.euerle@state.mn.us
Phone: 651-242-8846 Fax: 651-215-5963

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #: SL38174015 On May 24, 2022 the Minnesota Department of Health visited the above Temporary Comprehensive home care licensed provider. At the time of the survey there were 16 residents receiving services under the Provisional Assisted Living Facility license. The following correction order is issued/orders are issued for SL38174015, tag identification 0470, 0680, 0730, 810, 1460, 1470, 2040 and 2310.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 2 Based on observation, interview and record review, the licensee failed to ensure a required staffing plan was developed. This had the potential to affect all of the licensee's 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 the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of 16 residents and had a current census of 16 residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. - ensured 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 - ensured 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. During the provisional assisted living facility (PALF) entrance conference on May 24, 2022, at	0 470		

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0 470	Continued From page 3 approximately 11:00 a.m., the surveyor requested a copy of the facility's staffing plan. Registered nurse (RN)-A stated the facility does not have a documented staffing plan in place. The licensee failed to post a 24-hour staffing schedule in a central location. The licensee displayed a staffing schedule for the current month of May 2022 inside the facility's food preparation area with staff access only. The licensee's Staffing, Direct-care Staffing Plan & Daily Schedule policy dated May 11, 2022, stated the licensee would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The licensee's Staffing, Direct-care Staffing Plan & Daily Schedule policy dated May 11, 2022, stated that the daily work schedule will be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 480		

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0 480	Continued From page 4 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 26, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 5 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the facility emergency preparedness plan contained all the required components. This had the potential to affect the sixteen (16) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 6 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On May 24, 2022, at approximately 11:00 a.m., during the entrance conference with the administrator and registered nurse (RN)-A, a request was made to view the licensee's emergency preparedness (EP) plan. The plan was centrally located in the facility's food preparation area and contained a 13-page undated packet, titled "Emergency Action Plan". The licensee's plan lacked the following required content: - Develop and Maintain EP Program - Maintain and Annual EP Updates - EP Program Patient Population - Process for EP Collaboration - Subsistence Needs for Staff and Patients - Procedures for Tracking of Staff and Patients - Policies and Procedures for Volunteers - Arrangement with Other Facilities - Roles under a Waiver Declared by Secretary - Development of Communication Plan - Primary/Alternate Means for Communication - Methods for Sharing Information - Sharing Information on Occupancy/Needs - LTC Family Notifications - Emergency Prep Training and Testing - Emergency Prep Training Program - Emergency Prep Testing Requirements - Integrated Health Systems On May 25th, 2022, the surveyor reviewed the	0 680		

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0 680	Continued From page 7 emergency preparedness plan and components with the administrator and RN-A, who verified the plan was missing requirements. The licensee's undated policy titled Emergency and Disaster Preparedness indicated the facility would be prepared to manage emergency and disaster situations, including missing residents through a hazard assessment and emergency planning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 8 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written acknowledgement of receipt of the current Minnesota Assisted Living Bill of Rights (BOR) for two of two residents (R1, R2) with records reviewed. 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	0 730		

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0 730	Continued From page 9 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 had an admission date of June 29, 2016. R1's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R2 had an admission date of May 31, 2018. R2's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. On May 24, 2022, at approximately 1:00 p.m., the administrator stated all residents had received a copy of the BOR as included in policy. The administrator further stated the licensee was not aware the BOR which was signed by all residents was an incorrect version. The licensee's notice of resident rights policy dated May 11, 2022, indicated the licensee would obtain written acknowledgement that the resident received the bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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	0 810			

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0 810	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 26, 2022, at approximately 9:50 a.m. with the Administrator and Registered Nurse (RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, Administrator indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan included procedures for evacuation but did not include procedures for resident movement or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, Administrator indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, Administrator indicated that licensee does not have documentation or a policy on employee training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who able to assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. During interview, Administrator indicated that licensee does not have documentation or a policy on resident training on the actions to be taken in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, Administrator indicated that licensee does not have documentation of any conducted evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each	01460		

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01460	Continued From page 13 staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for two of two employees, unlicensed personnel (ULP-(B) and ULP-D, with records reviewed. This had the potential to affect all residents receiving assisted living 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 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: ULP-B was hired August 29, 2017, under the comprehensive home care license. ULP-B began providing assisted living services to licensee's residents on August 1, 2021. ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. ULP-D was hired on July 16, 2020, under the comprehensive home care license. ULP-D began providing assisted living services on August 1, 2021. ULP-D's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes.	01460		

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01460	Continued From page 14 On May 25, 2022, registered nurse/director of nursing (RN)-A stated orientation to 144G statutes had not been completed. The licensee's Assisted Living & Assisted Living with Memory Care orientation policy - all staff policy regarding training for 144G/assisted living statutes dated May 11, 2022, stated newly hired staff will receive orientation and training on topics required for assisted living organizations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01460		
01470 SS=F	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	01470		

Minnesota Department of Health

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01470	Continued From page 15 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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 orientation to assisted living licensing requirements and regulations was provided for two of two employees, unlicensed personnel (ULP-(B) and ULP-D, with records	01470		

Minnesota Department of Health

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01470	Continued From page 16 reviewed. This had the potential to affect all residents receiving assisted living 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 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: ULP-B was hired August 29, 2017, under the comprehensive home care license. As of August 1, 2021 the facility began operation under the assisted living licensure under 144G statutes. ULP-B began providing assisted living services to licensee's residents on August 1, 2021. ULP-B's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. ULP-D was hired on July 16, 2020, under the comprehensive home care license. As of August 1, 2021 the facility began operation under the assisted living licensure under 144G statutes. ULP-D began providing assisted living services on August 1, 2021. ULP-D's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. ULP-B and ULP-D's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes, including the following content: -An overview of 144G statutes -An introduction and review of the facility's policies and procedures related to the provision of	01470		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/26/2022
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01470	Continued From page 17 assisted living services -Handling of emergencies and use of emergency services -Compliance with and reporting of the maltreatment of vulnerable adults -The assisted living bill of rights -The principles of person-centered planning and service delivery -Handling of resident complaints, reporting of complaints, and where to report complaints -Consumer advocacy services of the office of the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure On May 25, 2022, registered nurse/director of nursing (RN)-A stated orientation to 144G statutes had not been completed. The licensee's Assisted Living & Assisted Living with Memory Care orientation policy dated May 11, 2022, stated newly hired staff will receive orientation and training on topics required for assisted living organizations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the	02040			

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02040	Continued From page 18 requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 26, 2022, at approximately 9:50 a.m. with the Administrator and Registered Nurse (RN)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a	02040		

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02040	Continued From page 19 hazard vulnerability assessment with mitigation factors on and around the property. During interview, Administrator stated that licensee had conducted a hazard vulnerability assessment for the emergency disaster plan for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	02310		

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02310	Continued From page 20 The findings include: On May 24, 2022, at approximately 1:30 p.m., four (4) unsecured oxygen cylinders were observed laying unsecured on the floor of a resident's (R5) room between a recliner and the closet doors. On May 24, 2022, at approximately 2:00 p.m., registered nurse (RN)-A confirmed she was aware that the oxygen tanks were set unsecured on the apartment floor. Minnesota Department of Health (MDH) internal document titled, Oxygen Cylinder Storage Requirements, dated April 16, 2020, which was based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code states: Volumes between 300 ft³ and 3000 ft³ of oxygen must be stored in special designated rooms that meet the following requirements: -Rooms must be non-combustible or limited-combustible construction (gypsum wallboard, tiled walls, etc.) with a door that can be secured from unauthorized entry (i.e. Locked). -Oxygen may not be stored with other flammable gases or liquids. -Oxygen cylinders must maintain a minimum distance of 20 ft. from combustibles (5 ft. if room is sprinklered), or placed within an enclosed cabinet having a fire rating of at least ½ hour. -Cylinders must be secured in racks or by chains. Per the licensee's Storage of Medications policy, dated May 21, 2022, medications will be handled and stored per acceptable standards. No further information was provided.	02310			

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02310	Continued From page 21 TIME PERIOD FOR CORRECTION: Two (2) days	02310			

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Report: 1033221036

Food and Beverage Establishment Inspection Report

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Location:

Golden Hearts, Inc.
602 Marion Drive
Arlington, MN55307
Sibley County, 72

Establishment Info:

ID #: 0013973
Risk: Low
Announced Inspection: No

License Categories:

FBLB, HOSP, FBLE-16, FBC2

Expires on: 12/31/22

Operator:

Golden Hearts, Inc.

Phone #: 5079642111
ID #: 15833

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

Eggs and fish are above RTE items.

Comply By: 05/26/22

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Spray bottle with bleach was measured at 200+ppm.

Comply By: 05/26/22

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

Facility is using a lemon scented laundry bleach for sanitizing food contact surfaces. Manufacture does

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Food and Beverage Establishment Inspection Report

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not state this is allowed for sanitizing food contact surfaces.

Comply By: 05/26/22

6-300 Physical Facility Numbers and Capacities

6-301.12

**** Priority 2 ****

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

No paper towel dispenser near hand sink.

Comply By: 06/09/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Facility does not have a CFPM.

Comply By: 08/25/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility is using a residential dish washer, pressure cooker, and rice cooker.

Comply By: 08/25/22

Surface and Equipment Sanitizers

Chlorine: = 200> at Degrees Fahrenheit

Location: Spray Bottle

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: Raw Burger-Cooler

Violation Issued: No

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: Soup-Cooler

Violation Issued: No

Process/Item: Cold Holding

Temperature: 0> Degrees Fahrenheit - Location: Freezer

Violation Issued: No

Type: Full
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Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the inspection report number 1033221036 of 05/26/22.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Larry Kicker

Signed:  _____

Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us