Electronically Delivered

March 25, 2026

Licensee
Covenant Living of Golden Valley Assisted Living
5800 St Croix Avenue North
Golden Valley, MN 55422

RE: Project Number(s) SL21715016

Dear Licensee:

On March 5, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 4, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Shoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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Electronically Delivered

January 29, 2026

Licensee
Covenant Living of Golden Valley Assisted Living
5800 St Croix Avenue North
Golden Valley, MN 55422

RE: Project Number(s) SL21715016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21715	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5800 ST CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21715016-0 On December 1, 2025, through December 4, 2025, 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 37 residents; receiving services under the Assisted Living Facility license. On December 1, 2025, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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 staff 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, 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 staff; (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	0 250		

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0 250	Continued From page 2 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 by the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to cooperate with a survey when the licensee denied the surveyor access to apartments on floors one, four, and five. 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: On December 2, 2025, at 11:00 a.m., the surveyor interviewed licensed assisted living director (LALD)-C, regional director of facilities	0 250		

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0 250	Continued From page 3 (RDF)-G, and maintenance supervisor (MS)-H. The surveyor explained the itinerary of the engineering survey process which included going into resident apartments throughout the licensed area. LALD-C stated that the licensed assisted living area of the facility was located on levels 2 and 3. RDF-G then brought in the executive director (ED)-I of the facility; ED-I, explained that they would not be granting access to any independent resident apartments on floors one, four, and five because the facility does not considered those floors to be part of the licensed assisted living area. On December 2, 2025, from 10:30 a.m. and 2:30 p.m., the surveyor toured the facility with RDF-G and MS-H. The facility was a 5-story building with between 9 and 20 apartments on each level. On floors one, four, and five the surveyor was not granted access to any apartments and was instructed they could only walk through the common areas of each floor. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 4 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480		

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0 480	Continued From page 5 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 6 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control to include appropriate use of gloves and hand hygiene for one of one employee (unlicensed personnel (ULP)-B). 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 December 2, 2025, at 7:40 a.m., the surveyor observed ULP-B apply gloves, obtain R6 and R7's medications from the medication cart and prepare morning medications for R6 and R7 at the same time. ULP-B placed the residents'	0 510		

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0 510	Continued From page 7 medications in separate, labeled medication cups with each resident's name. ULP-B then entered R6's apartment, placed the medication on the table, and assisted R6 with an inhaler. ULP-B left and went to R7's apartment without removing gloves or performing hand hygiene between residents. ULP-B informed R7 that she had placed the medication cup on the table, and she then assisted R7 by applying powder under breast while still wearing the same gloves she had used for R6. ULP-B stated that she usually changed gloves and performed hand hygiene between residents, however she was nervous and forgot to change gloves. On December 2, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated staff were trained on proper hand hygiene, and to wash hands after the removal of gloves and in between resident cares. CNS-A stated that she would retrain staff. The licensee's Hand Hygiene policy, undated, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gowns e. Before eating and after using a restroom No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	0 510		

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0 510	Continued From page 8 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 licensee's grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors and 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, but was not likely to	0 550		

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0 550	Continued From page 9 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: On December 1, 2025, at 11:30 a.m., during a facility tour, the surveyor observed the licensee lacked posting in a conspicuous place about the licensee's 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. On December 1, 2025, at 11:30 a.m., licensed assisted living director (LALD)-C confirmed the required content had not been posted. LALD-C stated the required posting was removed during remodeling work and acknowledged that it has not yet been reposted. The licensee's Complaint Policy and Procedure, undated, indicated residents, designated representatives, families, and other stakeholders have a system to report a complaint regarding services provided or other situations related to the facility. The policy would be posted in a conspicuous location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 550		

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0 550	Continued From page 10 days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 10:30 a.m., upon entering the facility, the surveyor observed the original current license was not posted at the facility entrance as required. On December 1, 2025, at 11:30 a.m., during a facility tour with licensed assisted living director (LALD)-C, the surveyor observed the license was posted on the third floor and was not posted at the main entrance as required. On December 1, 2025, at 11:40 a.m., LALD-C acknowledged the license was not posted at the	0 570		

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	21715	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5800 ST CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
0 570	Continued From page 11 front entrance as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include an	0 650		

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0 650	Continued From page 12 annual performance evaluation for one of two employees (clinical nurse supervisor (CNS)-A). 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: CNS-A was hired August 22, 2022, and provided direct care services to the licensee's residents. CNS-A's record lacked evidence of annual performance reviews to identify areas of improvement needed and training needs. During interview on December 2, 2025, at 3:30 p.m., licensed assisted living director (LALD)-C acknowledged CNS-A's record was missing evidence of an annual performance review. LALD-C stated they were aware of the required annul performance evaluation and they were undergoing staff transition and currently reviewing all files with human resource (HR) personnel but was not sure why it was not completed previously. The licensee's Personnel Records policy, undated, indicated performance evaluations identifying areas of improvement needed and training needs were performed annually. No further information was provided.	0 650		

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0 650	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	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 ensure employee tuberculosis (TB) symptom and history screenings were completed and documented for one of two employees (unlicensed personnel (ULP)-B). 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	0 660		

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0 660	Continued From page 14 situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated November 24, 2025, indicated the facility was low risk. ULP-B was hired on April 4, 2011, and began providing assisted living cares to licensee's residents. ULP-B's employee record included a one-step Mantoux test dated March 11, 2012, and an Annual TB Screening Tool for Healthcare Workers (HCWs) dated December 28, 2017. ULP-B's record lacked evidence of testing for TB with either a two-step Mantoux or an interferon-gamma release assay (IGRA) laboratory blood test as required. On December 2, 2025, at 2:00 p.m., licensed assisted living director (LALD)-C acknowledged ULP-B's record was missing a two-step tuberculin skin test (TST) or blood test as required. LALD-C stated they were undergoing staff transition and currently reviewing all files with human resource (HR) personnel but was not sure why it was not completed previously. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum	0 660		

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0 660	Continued From page 15 blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's TB Prevention and Control policy, undated, indicated upon hire all staff were tested for tuberculosis with either a two-step Mantoux or an IGRA laboratory blood test. The results of the TB test would be recorded and kept in the employee's medical file. If a staff member presented a two-step Mantoux with negative results or a negative IGRA test within 90-days of hire, this would be used for proof of negative result and the staff member did not need further testing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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;	0 680		

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0 680	Continued From page 16 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on December 1, 2025, at 11:30 a.m., no emergency exit diagrams were observed to be posted on each floor and post an emergency disaster plan prominently.	0 680		

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0 680	Continued From page 17 The licensee's Emergency Operations Plan dated June 10, 2025, lacked the following required content: -post emergency exit diagrams on each floor; -post an emergency disaster plan prominently;and -evacuation plan (not customized for the facility). On December 3, 2025, at 12:30 p.m., licensed assisted living director (LALD)-C acknowledged the EPP was missing the required content mentioned above. LALD-C stated they were undergoing staff transition, and they would review and update the EPP. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 18 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in 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: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 19 Environment Inspection Report (PEIR) dated December 2, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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 affiliated to the licensee's health facility identification number (HFID) as required for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	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 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 finding include: ULP-E was hired June 22, 2009, and provided direct care services to the licensee's residents. ULP-E record included a background study dated February 18, 2025, affiliated to an another licensee owned by the same owner with HFID 30433. ULP-E's employee record included background study clearance completed December 1, 2025, after the survey was initiated. However, ULP-E's employee record lacked evidence the licensee affiliated a background study for ULP-E under the current HFID number. On December 1, 2025, at 3:30 p.m., licensed assisted living director (LALD)-C stated she was not aware that ULP-E's background study had not been affiliated to the current HFID. LALD-C stated human resources (HR) personnel were supposed to double check and completed the background studies. The licensee's Background Study policy, undated, indicated all employees, as well as contractors, and scheduled volunteers of the facility with direct resident contact would undergo a background study through the Department of Human Services (DHS). Only those with satisfactory results would continue to work with the facility and its residents.	01290		

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01290	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 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	01470		

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01470	Continued From page 22 services the staff member 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 employees received orientation to include all required content for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). 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	01470		

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01470	Continued From page 23 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: CNS-A CNS-A was hired August 22, 2022, and provided direct care services to the licensee's residents. ULP-B ULP-B was hired on April 4, 2011, and began providing assisted living cares to licensee's residents. CNS-A and ULP-B's records lacked documentation the following orientation topics were completed: -an overview of assisted living laws 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); and -consumer advocacy services. During interview on December 2, 2025, at 3:30 p.m., licensed assisted living director (LALD)-C acknowledged CNS-A and ULP-B's records were missing the above-mentioned assisted living orientation. LALD-C stated they were undergoing staff transition and currently reviewing all files with human resource (HR) personnel but was not	01470		

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01470	Continued From page 24 sure why the orientation was not completed previously. During interview on December 3, 2025, at 1:40 p.m., CNS-A stated the training was completed and she was going to email the documents to the surveyor, but no documentation was provided. The licensee's Assisted Living and Assisted Living with Dementia Care Orientation - All Staff policy, undated, indicated newly hired staff would receive orientation and training on topics required for assisted living organizations. All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21715	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5800 ST CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

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01500	Continued From page 25 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 26 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 employees received at least eight hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). 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: CNS-A CNS-A was hired August 22, 2022, and provided direct care services to the licensee's residents. ULP-B ULP-B was hired on April 4, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. CNS-A and ULP-B's records lacked evidence of annual training to include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 27 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

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01500	Continued From page 28 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. On December 2, 2025, at 3:30 p.m., licensed assisted living director (LALD)-C acknowledged CNS-A and ULP-B's records were missing the above-mentioned annual training. LALD-C stated they were undergoing staff transition and currently reviewing all files with human resource (HR) personnel but was not sure why the training was not completed previously. The licensee's Personnel Records policy, undated, indicated the employee record would contain records of all required in-service education for all staff providing services to residents including annual training and infection control training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530		

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01530	Continued From page 29 training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (clinical nurse supervisor (CNS-A), unlicensed personnel (ULP)-B). This had the potential to affect all residents and staff.	01530		

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01530	Continued From page 30 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: CNS-A CNS-A was hired August 22, 2022, and provided supervision of staff and direct care services to the residents. CNS-A's records lacked documentation CNS-A completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. ULP-B ULP-B was hired April 4, 2011, to provide direct care services to the residents of the facility. ULP-B's records lacked documentation ULP-B completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. During interview on December 2, 2025, at 3:30 p.m., licensed assisted living director (LALD)-C acknowledged CNS-A and ULP-B's records were missing documentation of the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. ALD-C stated they were undergoing staff transition and currently reviewing all files with human resource (HR) personnel.	01530		

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01530	Continued From page 31 The licensee's Assisted Living or Assisted Living with Dementia Care Dementia Training policy, undated, did not include two hours of mental health and de-escalation training to be completed by July 1, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620		

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01620	Continued From page 32 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for two of three residents (R2, R3). 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	01620		

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01620	Continued From page 33 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: R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, indicated R2 required the service of medication administration. R2's Assisted Living Assessment dated September 8, 2025, read, "Reason for Assessment: Admission." R2's Assisted Living Assessment dated October 16, 2025, read, "Reason for Assessment: 90-day." R2's record lacked an assessment no more than 14 calendar days after initiation of services. R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living signed August 7, 2024, indicated R3 received the service of a compression sleeve. R3's Assisted Living Assessment dated February 5, 2025, read, "Reason for Assessment: 90-day." R3's Assisted Living Assessment dated October 16, 2025, read, "Reason for Assessment: 90-day."	01620		

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01620	Continued From page 34 A total of 253 days had passed between R3's two assessments. On December 2, 2025, at 1:00 p.m., licensed assisted living director (LALD)-C stated licensee's previous clinical nurse supervisor was recently separated from company as they had not completed multiple assessments within the required timeframes. LALD-C stated the licensee was aware a 14-day assessment was required to be completed, and assessments could not go longer than 90 days between. LALD-C stated the licensee had worked to complete current assessments on all residents but was aware of assessments not being done within the required timeframes. The licensee's undated Initial and On-going Nursing Assessment of Resident policy indicated a 14-day assessment would be completed and on-going assessment would not exceed 90 days from the previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	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	01640		

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01640	Continued From page 35 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 that all services required by the current service plan were documented as provided to each resident according to the service plan for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on November 21, 2025. R1's Service Plan - Assisted Living dated November 21, 2025, indicated R1 received the	01640		

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01640	Continued From page 36 following services: medication administration, blood sugar checks, dressing, daily weights, transfer assist, ambulation assist, grooming assist, shower assist, toileting, laundry, bed linens, housekeeping, medication reorder, and escort on campus. R1's record lacked documentation the following services were provided as identified on R1's current service plan: dressing, daily weights, transfer assist, ambulation assist, grooming assist, shower assist, toileting, laundry, bed linens, housekeeping, and escort on campus. R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, indicated R2 received the following services: medication administration, hearing aid assistance, dressing assist, grooming assist, bathing assist, dining assist, toileting, bed making, housekeeping, bedding, assistance with heal boots, transfer assist, daily weights, mobility assist, and status checks. R2's record lacked documentation the following services were provided as identified on R2's current service plan: hearing aid assistance, dressing assist, grooming assist, bathing assist, dining assist, toileting, bed making, housekeeping, bedding, assistance with heal boots, transfer assist, daily weights, mobility assist, and status checks. R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living dated December 8, 2025, indicated R3 received the	01640		

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01640	Continued From page 37 following services: assist to cut up foods, dressing assist, grooming assist, shower assist, bedding change, lotion, television, and activities. R3's record lacked documentation the following services were provided as identified on R3's current service plan: assist to cut up foods, dressing assist, grooming assist, shower assist, bedding change, lotion, television, and activities. On December 3, 2025, at 11:10 a.m., licensed assisted living director (LALD)-C stated the licensee was not documenting services provided to any resident besides administration of medications or treatments if the resident received that service. LALD-C stated the licensee would need to review the licensee's electronic health record system to see if documentation of services was possible and how staff would document services when provided. The licensee's undated Resident Record policy indicated each resident's record would include documentation of all services provided as identified on each resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 38 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all the required content for three of three residents (R1, R2, R3). 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).	01650		

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	21715	A. BUILDING: _____ B. WING _____	12/04/2025

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01650	Continued From page 39 The findings include: R1 R1 was admitted on November 21, 2025. R1's Service Plan - Assisted Living dated November 21, 2025, indicated R1 received the following services: medication administration, blood sugar checks, dressing, daily weights, transfer assist, ambulation assist, grooming assist, shower assist, toileting, laundry, bed linens, housekeeping, medication reorder, and escort on campus. R1's service plan lacked identification of the schedule and methods of monitoring staff who would provide services. R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, indicated R2 received the following services: medication administration, hearing aid assistance, dressing assist, grooming assist, bathing assist, dining assist, toileting, bed making, housekeeping, bedding, assistance with heal boots, transfer assist, daily weights, mobility assist, and status checks. R2's service plan lacked identification of the schedule and methods of monitoring staff who would provide services. R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living dated December 8, 2025, indicated R3 received the	01650		

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01650	Continued From page 40 following services: assist to cut up foods, dressing assist, grooming assist, shower assist, bedding change, lotion, television, and activities. R3's service plan lacked identification of the schedule and methods of monitoring staff who would provide services. On December 2, 2025, at 1:45 p.m., licensed assisted living director (LALD)-C stated the licensee's service plan template used lacked the schedule and methods of monitoring staff who would provide services to residents. LALD-C stated the licensee was in the process of updating all residents' service plans to include the required content but had not completed each resident yet. The licensee's undated Contents of Service Plans policy indicated each resident service plan would include the missing content for the schedule and method of morning staff who provided services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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01730	Continued From page 41 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current	01730		

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01730	Continued From page 42 individualized medication management record to include all required content for two of three residents (R2, R3) and failed to included medication management services in a resident's service plan for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, indicated R2 received medication administration services and read, "staff to administer [R2's name] medication." R2's Assisted Living Assessment dated October 16, 2025, read, "staff manages resident medications (scheduled and PRN [as needed])." R2's medication management record lacked a description of the storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living dated	01730		

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01730	Continued From page 43 December 8, 2025, lacked indication that R3 required medication management services. R3's Assisted Living Assessment dated October 16, 2025, read, "Staff manages resident medications (scheduled and PRN)." R3's medication management record lacked being included on R3's service plan and lacked a description of the storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On December 3, 2025, at 12:15 p.m., licensed assisted living director (LALD)-C stated the licensee's assessment template which included the resident medication management record lacked storage of medication content. LALD-C stated the licensee was in the process of updating each resident service plan, assessments, and medication management records, and would ensure each resident had all required content. The licensee's undated Individualized Medication, Treatment & Therapy Management Plans policy indicated each resident medication management record would include identification of the storage of medications. The licensee's undated Contents of Service Plans policy indicated each service plan would include all services to be provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01760	Continued From page 44	01760		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for two of four residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 2, 2025, at 7:18 a.m., the surveyor	01760		

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01760	Continued From page 45 observed unlicensed personnel (ULP)-B obtain R6 and R7's medications from medication cart and prepared morning medications for R6 and R7 at the same time. ULP-B placed the residents' medications in separate, labeled medication cups. ULP-B then entered R6's apartment, placed the medication on the table, and assisted R6 by administering her inhaler. ULP-B left and went to R7's apartment and ULP-B informed R7 that she had placed the medication cup on the table, and she then assisted R7 by applying nystatin powder under breast. ULP-B stated R6 and R7 prefer to take medications with food and that she would be documenting later after the residents took the medications. ULP-B stated R6 and R7 usually took the medications in their room before they go to the dining room. ULP-B stated R6 and R7's family requested from staff to prepare the medications and give to the residents to self-administer. ULP-B stated that she did not inform the nurse and was acting based on the family's request. R6 R6's diagnoses included low back pain and muscle weakness. R6's Service Plan- Assisted Living dated November 13, 2025, unsigned, indicated R6 received services including medication administration, status checks, housekeeping. and bed making. R7 R7's diagnoses included acute respiratory failure. R7's Service Plan- Assisted Living dated November 1, 2025, unsigned, indicated R7 received services including medication administration, meal reminders, shower,	01760		

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01760	Continued From page 46 housekeeping, and bed making. On December 2, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A acknowledged R6 and R7's medications were not administered according to prescriber orders. CNS-A stated they were not aware that R6 and R7's families requested staff to prepare the medications and give to the residents to self-administer. Also, CNS-A stated that she would retrain staff. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, undated, indicated medications, treatments and therapies always needed to be administered according to the "6 Rights" a. Right person; b. Right medication, treatment or therapy; d. Right route (by mouth, eye drops, to the skin, etc.); e. Right dose (how many milligrams, drops, etc); and f. Right chart/record to document that the medication, treatment, and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	01880		

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01880	Continued From page 47 by: Based on observation, interview, and record review the licensee failed to ensure medications were securely stored for one of four residents (R2) who had medication management 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, 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: R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, indicated R2 received Medication Administration services and read, "staff to administer [R2's name] medication." R2's Assisted Living Assessment dated October 16, 2025, read, "staff manages resident medications (scheduled and PRN [as needed])." The assessment included a medication list of all medications R2 was prescribed and administered by licensee to review for potential contraindications, but the medication list lacked addressing the OTC medications observed above. R2's individualized medication management record lacked identification of how and where R2's medications would be stored and if R2 was able to self-administer or store OTC medications	01880		

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01880	Continued From page 48 safely. On December 2, 2025, at 1:25 p.m., the surveyors observed that the medication cart on the third floor was unlocked and unattended and visitors were around. On December 2, 2025, at 1:30 p.m., licensed assisted living director (LALD)-C stated all medications for R2 should have been secured in the licensee's medication cart. LALD-C stated R2's should not have access to the identified OTC medications located unsecured in R2 apartment. LALD-C stated R2's OTC medications would need to be reviewed for accuracy and ensure no contraindications were noted from the other medications R2 was prescribed. On December 2, 2025, at 2:30 p.m., LALD-C stated staff were trained to lock medication cart at all times. The licensee's undated Storage of Medications policy indicated each resident would have a registered nurse assessment identify proper medication storage and who would have access to medications. The licensee's undated Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy indicated the registered nurse would develop and implement procedures for unlicensed personnel to administer medications which included OTC medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01910	Continued From page 49	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01910		

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01910	Continued From page 50 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: R5 started services on June 26, 2025. R5's Service Plan - Assisted Living, undated and unsigned, indicated R5 received medication administration services twice daily. R5's Woodside Terrace Discharge Summary indicated R5 discharged from the facility on November 10, 2025. R5's record lacked documentation of R1's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On December 3, 2025, at 1:40 p.m., licensed assisted living director (LALD)-C stated the disposition of medications was not documented for discharged resident R5. LALD-C stated "I am going to be honest with you. The nurse left us boxes full of documents, and we need to go through them to determine whether she has the documentation or not. At this time, we do not know if she completed or not." Also, clinical nurse supervisor (CNS)-A stated they have processes in place to document in the resident's record the disposition of the medication. The licensee's Disposition or Disposal of Medication policy, undated, indicated staff would	01910		

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01910	Continued From page 51 document in the resident's record the name of the person to whom the medications were given, the time, and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 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	01940		

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01940	Continued From page 52 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, implement, and include on the service plan an individualized treatment management plan (ITMP) to include all required content for two of three residents (R2, R3) who had a treatment. 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: R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, lacked indication R2 required a treatment plan for a provider order related to oxygen (O2) use. R2's untitled document identified by licensed assisted living director (LALD)-C as a progress note from R2's primary care provider read, "Assist with placement of nasal cannula at bedtime. Only uses during sleep. Has order for	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21715	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5800 ST CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

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01940	Continued From page 53 private use." R2's After Visit Summary (AVS) dated October 9, 2025, was authenticated by R2's primary care provider and included the following order, "oxygen-air delivery systems. Oxygen for home use with bubbler/humidity as needed for patient comfort. Liters per minute: 2 per nasal cannula." R2's Assisted Living Assessment dated October 16, 2025, read, "Oxygen. Resident can manage oxygen usage, and staff assists in managing supplies (ordering, storing)," and "Resident does not receive special medications/treatments." R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living signed August 7, 2024, indicated R3 received dressing assist for a compression sleeve (called a Tubigrip sock) to R3's left leg. R3's Follow-up Visit dated September 19, 2025, indicated R3's provider addressed R3's compression garment and referred R3 to home care registered nurse to follow related to swelling and bruising in the lower left leg. R3's [home care company name] Healthcare Residential Communication Notes dated September 24, 2025, and October 31, 2025, both indicated R3 required the Tubigrip sock to protect skin. R3's Assisted Living Assessment dated October 16, 2025, read, "set-up clothes and assist tubi grips." R2 and R3's ITMP lacked the following required	01940		

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01940	Continued From page 54 content: - documentation of specific resident instructions relating to the treatments; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; 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 December 3, 2025, at 12:15 p.m., LALD-C stated a treatment plan should have been completed for R2 and R3. LALD-C stated the licensee's previous clinical nurse supervisor failed to complete multiple items for R2 and R3's ITMPs. LALD-C stated the licensee was in the process of reassessing every resident to ensure all services and treatment plans were completed but had not completed them for R2 or R3 yet. The licensee's undated Individualized Medication, Treatment & Therapy Management Plans policy indicated the missing content from R2 and R3's ITMP would be developed, implemented, and included in the resident's records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

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01960	Continued From page 55 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were documented as administered, or documented as to why they were not administered, for two of three residents (R2, R3) who had a treatment. 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: R2 R2 was admitted on September 8, 2025. R2's Service Plan - Assisted Living dated September 8, 2025, lacked indication R2 required a treatment plan for a provider order related to oxygen (O2) use. R2's untitled document identified by licensed	01960		

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01960	Continued From page 56 assisted living director (LALD)-C as a progress note from R2's primary care provider read, "Assist with placement of nasal cannula at bedtime. Only uses during sleep. Has order for private use." R2's After Visit Summary (AVS) dated October 9, 2025, was authenticated by R2's primary care provider and included the following order, "oxygen-air delivery systems. Oxygen for home use with bubbler/humidity as needed for patient comfort. Liters per minute: 2 per nasal cannula." R2's Assisted Living Assessment dated October 16, 2025, read, "Oxygen. Resident can manage oxygen usage, and staff assists in managing supplies (ordering, storing)," and "Resident does not receive special medications/treatments." R3 R3 was admitted on August 8, 2024. R3's Service Plan - Assisted Living signed August 7, 2024, indicated R3 received dressing assist for a compression sleeve (called a Tubigrip sock) to R3's left leg. R3's Follow-up Visit dated September 19, 2025, indicated R3's provider addressed R3's compression garment and referred R3 to home care registered nurse to follow related to swelling and bruising in the lower left leg. R3's [home care company name] Healthcare Residential Communication Notes dated September 24, 20225, and October 31, 2025, both indicated R3 required the Tubigrip sock to protect skin. R3's Assisted Living Assessment dated October	01960		

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01960	Continued From page 57 16, 2025, read, "set-up clothes and assist tubi grips." R2 and R3's ITMP lacked documentation of the administration of R2 and R3's treatments. On December 3, 2025, at 12:15 p.m., LALD-C stated a treatment plan should have been completed for R2 and R3 and documentation of the administration of the treatments should have been in the resident records. LALD-C stated licensee was in the process of reassessing every resident to ensure all services and treatment plans were completed but had not completed them for R2 or R3 yet. The licensee's undated Documentation of Medication, Treatment and Therapy Management Services policy indicated staff would document all treatments immediately after the task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02310	During the course of the survey, the	

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02310	Continued From page 58 review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for three of three residents with hospital bed rails (R1, R2, R4). 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 widespread 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 On December 1, 2025, at 1:00 p.m., the surveyor observed R1 sitting on his bed. R1's hospital bed was equipped with two half bed rails in the upright position which were attached to the bed. Clinical nurse supervisor (CNS)-A grasped the bed rail and noted the bed rail was secured to the bed and did not move when pulled and pushed on with force. R1's diagnoses included but were not limited to diabetes and muscle weakness. R1's Service Plan dated November 24, 2025, indicated R1 needed assistance with transfers, dressing, grooming, bathing, and medication administration. R1's Assisted Living (Nursing) Assessment dated November 24, 2025, lacked a bed rail assessment.	02310	licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 59 R1's record included a bed rail consent form dated November 21, 2025. R1's record lacked documentation of an individualized bed rail assessment and specific measurements of the zones of entrapment. R2 On December 1, 2025, at 1:10 p.m., the surveyor observed R2 sitting on his bed. R2's hospital bed had a bed rail on both sides of the bed, which were attached to the bed. CNS-A grasped the bed rail and noted the bed rail was loose when moved left to right. R2's diagnoses included but were not limited to congestive heart failure and acute pulmonary edema. R2's Service Plan dated September 8, 2025, indicated R2 needed assistance with dressing, grooming, bathing, and medication administration. R2's Assisted Living (Nursing) Assessment dated October 24, 2025, lacked a bed rail assessment. R2's record lacked documentation of an individualized bed rail assessment, specific measurements of the zones of entrapment, and documentation the risk and benefits of bed rails were discussed with R2 or R2's responsible party. R4 On December 2, 2025, at 8:45 a.m., the surveyor observed R4's hospital bed had a bed rail on both sides of the bed, which were attached to the bed. Unlicensed personnel (ULP)-B grasped the bed rail and noted the bed rail was secured to the bed	02310		

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02310	Continued From page 60 and did not move when pulled and pushed on with force. R4's diagnoses included but were not limited to chronic kidney disease and pain in the right shoulder. R4's Service Plan, undated and unsigned, indicated R4 needed assistance with dressing, showering, and meal reminders. R4's Assisted Living (Nursing) Assessment October 24, 2025, lacked a bed rail assessment. R4's record lacked documentation of an individualized bed rail assessment, specific measurements of the zones of entrapment, and documentation the risk and benefits of bed rails were discussed with R4 or R4's responsible party. On December 1, 2025, at 2:00 p.m., CNS-A confirmed R1 and R2 had bed rails and stated she was not aware R2 had a bed rail. CNS-A verified the bed rails were not assessed, including measurements of the zones of entrapments. On December 2, 2025, at 9:00 a.m., CNS-A confirmed R4 had bed rails. CNS-A stated she was not aware R4 had bed rails and R4's family installed the bed rails. CNS-A verified the bed rails were not assessed, including measurements of the zones of entrapment. CNS-A stated the licensee used and application that didn't include a bed rail assessment. Additionally, CNS-A stated she did not know that she needed to complete a bed rail assessment for assisted living residents since she previously worked in in a differently licensed facility type. The March 10, 2006, Food and Drug	02310		

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02310	Continued From page 61 Administration (FDA) Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA's, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The license's undated Devices and Device Assessment policy indicated the following: 1. If the resident expresses the desire to use a device or a device is in use / recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and /or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per	02310		

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02310	Continued From page 62 FDA guidelines. b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident's record to include: a. Results of the assessment. b. Discussion with resident/responsible party regarding risks and benefits and alternatives considered/recommended. c. Decision made/outcome of discussion. 5. Staff will be educated to report to a licensed nurse immediately if the device is found to be loose or malfunctioning. 6. Physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Director of Health Services, or Housing Director will be notified immediately. 7. Maintenance staff will inspect bed and mattress for zone safety on a monthly basis. 8. Maintenance staff will inspect bed devices monthly. If the device has become loose/unstable in any way it will be removed, and the responsible party will be notified. Or may choose to have maintenance attempt to secure the device and if unable remove it and notify the responsible party. 9. Two times per year the Clinical Nurse Supervisor, or designee, will check the FDA website for recalls on bed assistive devices. Customize how you'll monitor for this -you can either search the FDA database or sign up for the FDA email subscription where you can choose your device. 10. If a licensed nurse, or other designee believes that the assistive device laces the resident at risk for harm (i.e. Unable to use safely etc.) it will be removed, and the family will be notified.	02310		

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02310	Continued From page 63 The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions (FAQs) website dated October 13, 2025, indicated when hospital style bed rails were in use, documentation about a resident's bed rails should include, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received assisted living services from staff who	02320		

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02320	Continued From page 64 were trained and competent when an unlicensed personnel (ULP) set up medications for later administration for two of four residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 2, 2025, at 7:18 a.m., the surveyor observed ULP-B obtain R6 and R7's medications from the medication cart and prepare morning medications for R6 and R7 at the same time. ULP-B placed the residents' medications in separate, labeled medication cups. ULP-B then entered R6's apartment, placed the medication on the table, and assisted R6 by administering her inhaler. ULP-B left and went to R7's apartment and ULP-B informed R7 that she had placed the medication cup on the table, and she then assisted R7 by applying nystatin powder under breast. ULP-B stated R6 and R7 prefer to take medications with food and that she would be documenting later after the residents took the medications. ULP-B stated R6 and R7 usually took the medications in their room before they went to the dining room. ULP-B stated R6 and R7's family requested from staff to prepare the medications and give to the residents to self-administer. ULP-B stated that she did not inform the nurse and was acting based on the family's request.	02320		

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02320	Continued From page 65 R6 R6's diagnoses included low back pain and muscle weakness. R6's Service Plan- Assisted Living dated November 13, 2025, unsigned, indicated R6 received services including medication administration, status checks, housekeeping. and bed making. R7 R7's diagnoses included acute respiratory failure. R7's Service Plan- Assisted Living dated November 1, 2025, unsigned, indicated R7 received services including medication administration, meal reminders, shower, housekeeping, and bed making. On December 2, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A acknowledged R6 and R7's medications were being set up by the ULP for later administration. CNS-A stated they were not aware that R6 and R7's families requested staff to prepare the medications and give to the residents to self-administer. Also, CNS-A stated that she would retrain staff. Minnesota Statute 144G.08 subdivision 41 dated 2025, defined medication setup as arranging of medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Clgv Assisted Living
5800 St Croix Avenue North
Golden Valley, MN 55422
Hennepin County
Parcel:

Phone:

License Info

License: HFID 21715

Risk:
License:
Expires on:
CFPM: Patrick Tuomala
CFPM #: CFPM 41337; Exp: 2/9/2028

Inspection Info

Report Number: F1039251217
Inspection Type: Full - Single
Date: 12/2/2025 Time: 11
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: WIPING CLOTHS HELD ON COUNTER, ATOP INGREDIENT BIN. CLOTHS REMOVED FOR LAUNDERING. CORRECTED ON SITE.
Comply By: Complied On Site Originally Issued On: 12/2/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.12 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0305 Do not store food in locker rooms, toilet rooms, dressing rooms, garbage rooms, mechanical rooms, under unprotected sewer lines, under leaking water lines, under water lines on which water has condensed, under open stairwells, or under other sources of contamination.
COMMENT: ROOM STORING BOTTLED SODA AND SODA SYRUP MIXING EQUIPMENT HAS EXPOSED SEWER PIPING IN CEILING ABOVE SODA AND EQUIPMENT. MAKE PLANS TO ADD DROP CEILING, PIPE CHASE OR OTHERWISE PROTECT SODA AND EQUIPMENT FROM SEWER PIPING OR MOVE SODA AND EQUIPMENT TO ALTERNATE LOCATION.
Comply By: 2/1/2026 Originally Issued On: 12/2/2025

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT: CAULKING TO WALL ON DIRTY SIDE DRAIN BOARD AT DISH AREA IS IN BAD REPAIR. REPLACE CAULKING.
Comply By: 1/31/2026 Originally Issued On: 12/2/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: COUNTERTOP COOLER IN BISTRO AREA HAS SOILS ACCUMULATED ON OUTER SURFACES. COMPLY WITH ABOVE RULE AND THEN MAINTAIN COOLER OUTER SURFACES CLEAN.
Comply By: 12/5/2025 Originally Issued On: 12/2/2025

Food & Beverage General Comment

COOKED CHICKEN - COLD HOLD, PREP COOLER AT GRILL, INSERT - 40 DEGREES F
MILK - COLD HOLD, WALK-IN COOLER - 39 DEGREES F
DELI MEAT - COLD HOLD, WALK-IN COOLER - 39 DEGREES F
CUT MELON - COLD HOLD, LARGE KITCHEN REACH-IN - 40 DEGREES F
COOKED FISH - HOLD, KITCHEN HOT BOX - 148 DEGREES F
BAGGED PRODUCE - HOLD IN PRODUCE WALK-IN - 39 DEGREES F
COOKED CHICKEN - COLD HOLD, BISTRO GRILL DRAWER - 40 DEGREES F
CUT TOMATO - COLD HOLD, BISTRO REACH-IN COOLER - 39 DEGREES F
CHEESE STICK - COLD HOLD, BISTRO DISPLAY COOLER - 38 DEGREES F
COOKED QUINOA - HOT HOLD, BISTRO STEAM TABLE - 153 DEGREES F
COOKED FISH - HOT HOLD, 2ND FLOOR, STEAM TABLE - 147 DEGREES F
BUTTER - COLD HOLD, 2ND FLOOR REACH-IN COOLER - 39 DEGREES F
COOKED FISH - HOT HOLD, 3RD FLOOR, STEAM TABLE - 157 DEGREES F
BUTTER - COLD HOLD, 3RD FLOOR REACH-IN COOLER - 40 DEGREES F

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the persons-in-charge and reviewed with MDH HRD nurse evaluator Safia Hassan.

Food service areas consist of a main kitchen with bistro/grill area on first floor and satellite kitchens on 2nd and 3rd floors.

Discussed the following topics with the persons-in-charge: food source, cooling TCS hot TCS foods, foodborne illness symptoms and exclusion of ill employees, hand hygiene, cleaning and sanitizing, preventing contamination, date marking, all orders on this report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039251217 from 12/2/2025

Patrick Tuomala
Dining Director

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Sanitizer Observations/Recordings

Establishment Info

Clgv Assisted Living
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1039251217
Inspection Type: Full
Date: 12/2/2025
Time: 11

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: MAIN KITCHEN **Equal To** 169 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: 3RD FLOOR SATELLITE KITCHEN **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** Dispenser
Location: MAIN KITCHEN **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** Dispenser
Location: 3RD FLOOR SATELLITE KITCHEN **Equal To** 272 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL21715016-0	**Date:** December 2, 2025
Facility Name: CLGV ASSISTED LIVING (Covenant Living of Golden Valley)	
Facility Address: 5800 ST. CROIX AVENUE N, GOLDEN VALLEY, MN 55422	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Facility had resident procedures in a different policy/plan and will add to the FSEP.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or if the information is located in a separate location and how to access. The plan also fails to instruct staff what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. .

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested all staff training on the FSEP from the licensed assisted living director (LALD)-A. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated the facility is using a third-party website for staff training, and they were new to the position. LALD-A was unaware of where other, if any, documents were kept that documented staff training. No other staff training documentation was provided.

5. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested all resident training documents on the FSEP from the LALD-A. The licensee failed to provide evacuation training to residents at least once per year. The new LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

6. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested recorded evacuation drill documentation from the LALD-A. The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A provided drills that showed evacuation drills took place 1-28-25, 7-28-25, 8-15-25, 9-30-25, 10-23-25, 11-14-25.

DEPARTMENT OF HEALTH