Electronically Delivered

November 9, 2023

Licensee
Global Pointe Senior Living
5200 Wayzata Boulevard
Golden Valley, MN 55416

RE: Project Number(s) SL35621015

Dear Licensee:

On October 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 7, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 8, 2023

Licensee
Global Pointe Senior Living
5200 Wayzata Boulevard
Golden Valley, MN 55416

RE: Project Number(s) SL35621015

Dear Licensee:

On September 6, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 7, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 7, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on July 7, 2023, found not corrected at the time of the September 6, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1 - $3,000.00
2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35621	A. BUILDING: _____ B. WING _____	R 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35621015-1 On September 5, 2023, to September 6, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 7, 2023. At the time of the survey, there were 91 residents: 53 of whom were receiving services under the Assisted Living (with Dementia Care) license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	{0 650}		

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{0 650}	Continued From page 1 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	{0 660}		

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{0 660}	Continued From page 2 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: No further action required.	{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; 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	{0 680}		

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{0 680}	Continued From page 3 requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	{0 730}		

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{0 730}	Continued From page 4 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	{0 810}		

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{0 810}	Continued From page 5 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}		

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{01060}	Continued From page 6	{01060}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	{01060}		

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{01060}	Continued From page 7 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-M). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	{01290}		

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{01290}	Continued From page 8 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-M ULP-M began employment with the licensee on July 20, 2023, to provide care and services under the licensee's Assisted Living with Dementia Care license. ULP-M's employee record contained a document titled Final Registry Results form. ULP-M's record lacked a background study clearance form. On September 5, 2023, at 2:04 p.m., the surveyor interviewed ULP-M regarding their current training status. ULP-M stated that they had just recently begun working without direct supervision as of September 3, 2023. ULP-M stated that they were not aware that their background check had not cleared and stated they were fingerprinted on July 27, 2023. On September 5, 2023, at 1250 p.m., RN-N stated that the provided documentation on background checks was all that was currently available, and that they had not yet received a clearance letter for ULP-M. On September 5, 2023, at 2:04 p.m., CNS-D stated "She has been doing her training with someone, but also this past weekend she was working independently as well. So, we will pull her from the schedule until we get her clearance."	{01290}		

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{01290}	Continued From page 9 No further information was provided.	{01290}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	{01650}		

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{01650}	Continued From page 10 (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; (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: No further action required.	{01650}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	{01760}		

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{01760}	Continued From page 11 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: No further action required.	{01760}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35621	A. BUILDING: _____ B. WING _____	R 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

(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
{01890}	Continued From page 12 No further action required.	{01890}		
{01910} SS=D	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: No further action required.	{01910}		
{02310} SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	{02310}		

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{02310}	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R12) who utilized a bed rail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12 R12's diagnoses include essential hypertension. R12's service plan included housekeeping, medication management, and daily wellness checks. R12's Side Rail assessment dated July 18, 2023, indicated that R12 utilized a consumer bed rail, model BA10W. The bed rail assessment indicated that the bed rail was recalled by the manufacturer. The bed rail assessment lacked information regarding safety interventions and alternatives offered by licensee to reduce the risk related to continued use of the recalled bed rail. The assessment question #5 indicated to describe the risk vs. benefit education provided with resident/representative and understanding of risk vs. benefit discussion. The question was answered with, "Education provided for risk vs.	{02310}		

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{02310}	Continued From page 14 benefit to resident". The assessment lacked evidence this education was individualized to the resident and the particular risks associated with use of a recalled bed rail. On September 5, 2023, at 2:17 p.m., CNS-D stated they had spoken with the family about replacing the bed rail, but the resident was adamant they keep their current bed rail. CNS-D stated they did not have documentation of this conversation with family. CNS-D stated there were no further interventions attempted. R12 was unavailable for interview during the survey. The licensee's Assessing the Safety of Side Rails policy dated October 1, 2014, and revised January 23, 2023, read, "When notified that a resident has a side rail, the RN will assess any evaluate what the resident's needs are and assess to determine if the resident can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. RN may consult with PT, OT and MD in making this decision. The RN will educate the resident, the resident's representative and/or the resident's family regarding side rail safety and risks including potential death due to falls, injuries, entrapment, and/or asphyxiation. If the RN determines that the resident is not able to safely use a side rail, or that the resident's side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail. If the RN determines that the side rails are not a safe	{02310}		

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{02310}	Continued From page 15 device for the resident, the RN will provide options to the client's [resident] representative and/or the client's [resident's] family. The RN will document these recommended options and the response from the resident, the resident's representative and/or the resident's family to the RN's recommendations. If the RN determines that a resident's side rail is unsafe, and the client [resident], the client's [resident's] representative or the client's [resident's] family does not remove it, the RN will notify the client's [resident's] physician and consider whether to notify MAARC." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	{02310}		

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{02310}	Continued From page 16 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information provided.	{02310}		

Electronically Delivered

July 6, 2023

Licensee
Global Pointe Senior Living
5200 Wayzata Boulevard
Golden Valley, MN 55416

RE: Project Number(s) SL35621015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 7, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

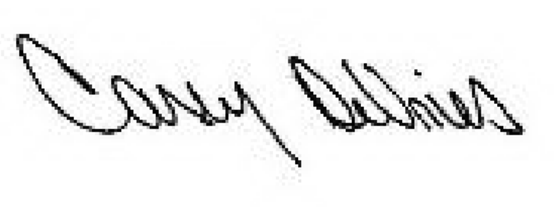
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35621	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35621015-0 On June 5, 2023, through June 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 103 active residents: 67 of whom received services under the Assisted Living with Dementia Care license. An immediate correction order was identified on June 5, 2023, issued for SL35621015-0, tag identification 2310. On June 7, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained and the scope and level remained unchanged. An immediate correction order was identified on June 6, 2023, issued for SL35621015-0, tag identification 1290.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On June 7, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained and the scope and level remained unchanged.	0 000		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B) with	0 650		

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0 650	Continued From page 2 employee records reviewed. 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: ULP-B started employment with the licensee on February 1, 2022. ULP-B's employee record lacked an annual performance review. On June 6, 2023, at approximately 1:14 p.m., CNS-D stated, "I am just starting annual appraisals now, so I only have a few done, so she [ULP-B] and most of the others won't have one completed for annual appraisals." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 3 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) 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. In addition, the licensee failed to ensure completion of a TB risk assessment, baseline TB screening, and completion of a two-step tuberculin skin test (TST) or TB screening such as a blood test at the time of hire for two of two employees (licensed practical nurse (LPN)-A and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 660		

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0 660	Continued From page 4 The findings include: TB RISK ASSESSMENT On June 5, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C provided surveyor with a TB risk assessment completed on May 12, 2022, for a different facility, with an address that was located in a different county than the licensee. LALD-C stated, "The risk assessment is for here, but I put the wrong identifying information in. I used the information from where I transferred here from." On June 5, 2023, at 3:30 p.m., LALD-C provided surveyor with a TB risk assessment for licensee, dated June 5, 2023, created during the survey. TB TESTING AND BASELINE SCREENING LPN-A LPN-A had a start date of September 9, 2022, to provide care and services under the licensee's Assisted Living with Dementia Care license. LPN-A's employee's record lacked evidence of the following: - TB history and symptom screening; and - two-step TST or blood test. ULP-B ULP-B had a start date of February 1, 2022, to provide care and services under the licensee's Assisted Living with Dementia Care license. ULP-B's employee's record lacked evidence of the following: - TB history and symptom screening; and - two-step TST or blood test. On June 6, 2023, at 12:55 p.m., business office manager (BOM)-E verified the above content was	0 660		

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0 660	Continued From page 5 missing from LPN-A's employee file. BOM-E stated that nurses are responsible for ensuring employees receive a TB history and symptom screening, and two-step TST or blood test upon hire. On June 6, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-D stated it was his responsibility to ensure TB history and symptom screening, and two-step TST or blood test were completed for all employees upon hire, and when CNS-D realized they had not been completed, CNS-D started completing them. The licensee's Tuberculosis Prevention and Control policy dated July 23, 2023, indicated at the time of hire and prior to contact with any clients [residents], all assisted living employees and all volunteers would be screened for tuberculosis. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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	35621	A. BUILDING: _____ B. WING _____	06/07/2023

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0 660	Continued From page 6 (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; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license.	0 680		

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0 680	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - subsistence needs for staff and residents including safe/sanitary storage of provisions, -policies and procedures for volunteers, and -roles under a waiver declared by secretary in accordance with section 1135 of the Act. On June 5, 2023, licensed assisted living director (LALD)-C acknowledged there were missing items and stated, "I have updated the needs for the subsistence's in the EPP binder, I will be working on getting the rest updated shortly." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 8 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 9 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for two of three discharged residents (R1 and R9). 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 admitted for services on December 5, 2022, and discharged to a different assisted living facility on April 26, 2023. R1's record lacked a discharge summary. R8 R8 admitted for services on December 2, 2020, and discharged to a different assisted living facility on January 10, 2023. R8's record lacked a discharge summary that was completed prior to the start of the survey. R9 R9 admitted for services on March 1, 2021, and	0 730		

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0 730	Continued From page 10 discharged to a different assisted living facility on January 10, 2023. R9's record lacked a discharge summary that was completed prior to the start of the survey. On June 6, 2023, at 9:35 a.m., clinical nurse supervisor (CNS)-D provided surveyors with two documents, one for R8 and one for R9, both titled, Discharge Summary, dated June 6, 2023, created during the survey. CNS-D stated, "I have not completed a discharge summary for any of the residents who I have discharged, but I am working to get them all done today." The licensee's Resident Records policy dated August 1, 2021, indicated resident records would include a discharge summary. No further information provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 11 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. 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	0 810		

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0 810	Continued From page 12 a large portion or all of the residents). Findings include: A record review and interview were conducted on June 6, 2023, at approximately 3:45 p.m. with Licensed Assisted Living Director (LALD)-C, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it	0 810		

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0 810	Continued From page 13 initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-C, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 103 residents living within the assisted living with Dementia Care facility. This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 14 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: Page 18 section 24.0 of R3, R4, and R5's contract titled Personal Property included: "Facility is not responsible for any loss or damage to Resident's personal property due to theft, or damage due to fire, water, tornado, or other acts of nature and events beyond Facility's control. Resident is strongly encouraged to keep items of significant financial or sentimental value stored in a bank safe deposit box, and to obtain renter's insurance. In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, Resident waives: (a) all claims against Facility and its representatives and agents for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such loss damage or destruction. On June 7, 2023, at 8:54 a.m., licensed assisted living director (LALD)-C stated, "I am aware that there can't be a liability in the contract, but I thought that had been changed. I will get that changed that in my master copy." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 16 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (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) 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: R3 R3 was admitted to licensee on January 20, 2023, and started receiving assisted living services. R3's service plan dated March 2, 2023, indicated R3 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, oral care assistance, grooming assistance, escorts, safety checks, change in condition notification to RN, housekeeping, and laundry assistance.	01060		

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01060	Continued From page 17 R3's progress note dated April 2, 2022, at 10:15 a.m., indicated direct care staff called RN-L to report that R3 had been experienced swelling, redness, and pinkish fluid draining from his left hip, where his left hip replacement had taken place. RN-L directed staff to call 911 to have R3 evaluated for infection of surgical wound at North Memorial hospital. Staff updated R3's son, and son accompanied R3 to the hospital. R3's progress note dated May 18, 2023, at 11:28 a.m., indicated R3 was readmitted to the licensee's facility from a transitional care facility. R3 was relocated from the facility for 46 days from April 2, 2023, through May 17, 2023. R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required. On June 6, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-D stated the licensee had not provided to the resident, resident's representative or to the ombudsman's office the required notices for emergency relocation as the facility was not aware of the requirement. CNS-D further stated they had not provided the required notices for any relocations because they did not know they should. Licensee's undated Contract Termination policy indicated licensee would provide a written notice to the resident, the resident's legal representative, and designated representative that contained, at a minimum:	01060		

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01060	Continued From page 18 - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - provide the resident or resident's representative a written emergency relocation notice; - provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 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	01290		

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01290	Continued From page 19 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of six employees (licensed assisted living director (LALD)-C, clinical nurse supervisor (CNS)-D, and unlicensed personnel (ULP)-F and ULP-G). This resulted in issuance of an immediate correction order on June 6, 2023, at approximately 3:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LALD-C LALD-C began employment with the licensee on March 21, 2022, to provide care and services under the licensee's Assisted Living with Dementia Care license. LALD-C's position description indicated they were responsible to manage continuum care property, maximizing the value of the owner's investment,	01290	On June 7, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope and level of "I".	

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01290	Continued From page 20 while balancing the needs of the residents and providing leadership to the property health care team. LALD-C's employee record contained a background study dated February 23, 2022, affiliated to another health facility identification number (HFID) 34963. LALD-C's record lacked evidence the licensee submitted a background study for LALD-C under the licensee's assisted living with dementia care license and affiliated to the licensee's HFID number. On June 6, 2023, at 10:05 a.m., LALD-C stated the background study on file was from their former employer, another assisted living facility under different ownership, however, asserted the former employer and the licensee were managed by the same management company. CNS-D CNS-D began employment with the licensee on October 10, 2022, to provide care and services under the licensee's Assisted Living with Dementia Care license. CNS-D's position description indicated they were responsible for ensuring the health and safety of all residents through assessments of the residents, development, and implementation of appropriate plans of care, supervision of the residents' services, supervision of the home care staff and on-going training of home care staff. On June 5, 2023, CNS-D completed assessments for residents (R)2 and R3. CNS-D's employee record lacked a background study. ULP-F	01290		

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01290	Continued From page 21 ULP-F began employment with the licensee on October 4, 2022, to provide care and services under the licensee's Assisted Living with Dementia Care license. ULP-F's employee record contained a background study dated September 16, 2022, affiliated to HFID 39034, another assisted living facility under different ownership. ULP-F's record lacked evidence the licensee submitted a background study for ULP-F under the licensee's assisted living with dementia care license and affiliated to the licensee's HFID number. On June 6, 2023, at 2:50 p.m., Building Office Manager (BOM)-E provided surveyor with a timecard titled Timecard dated April 23, 2023, through May 6, 2023. The timecard indicated ULP-F last worked on April 30, 2023. ULP-G ULP-G began employment with the licensee on January 20, 2023, to provide care and services under the licensee's Assisted Living with Dementia Care license. ULP-G's employee record contained a background study dated December 28, 2022, affiliated to HFID 39034, another assisted living facility under different ownership. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the licensee's assisted living with dementia care license and affiliated to the licensee's HFID number. On June 6, 2023, at 2:39 p.m., BOM-E provided surveyor with a timecard titled Individual Timecard dated May 1, 2023, through May 31, 2023. The timecard indicated ULP-G last worked on May 2, 2023.	01290		

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01290	Continued From page 22 On June 6, 2023, at 10:38 a.m. LALD-C stated, "CNS-D is an RN so I thought his nurse's license covered him and we don't need a background study done for him. [ULP-F] and [ULP-G] have a background study done at their other location. They are both casual and come over here two to three times a month to help us fill shifts, but they are based out of another building, which is one of their Greater Lakes sister campuses, but [CNS-D] would not be affiliated at all because our regional director at the time of [CNS-D's] hire had told us we did not need to run one as he was an RN and he was covered by the Board of Nursing running the background checks for nurses." LALD-C provided surveyor with the RN license for CNS-D that indicated CNS-D had been issued their RN license on March 13, 1986. On June 6, 2023, at 1:26 p.m., LALD-C provided information for three different sensitive information persons (SIP) for the above mentioned HFID numbers. Business Office Manager (BOM)-E was the SIP for HFID 35621 and is an employee of the licensee. SIP-I for HFID 34963 and SIP-J for HFID 39034 were not employees of the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 23 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 14-days after initiation of services and reassessments not to exceed 90 calendar days from the last date of the assessment for four of four residents (R3, R4, R5, and R7) as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01620		

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01620	Continued From page 24 The findings include: R3 R3 was admitted January 20, 2023, and had diagnoses to include unspecified dementia, presence of left artificial hip joint, metabolic encephalopathy, infection, and inflammatory reaction due to other internal joint prosthesis, altered mental status, paroxysmal atrial fibrillation, and essential (primary) hypertension. R3's Individual Service Plan dated March 2, 2023, indicated R3 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, oral care assistance, grooming assistance, escorts, safety checks, change in condition notification to RN, housekeeping, and laundry assistance. R3's record lacked documentation of a physical and cognitive reassessment no more than 14-days after initiation of services. R3's initial uniform assessment was completed on January 20, 2023. R3's ongoing reassessment was completed on March 13, 2023, thirty-seven days after the required 14-day reassessment date. R4 R4 was admitted May 26, 2021, and had diagnoses to include other chronic pain, diabetes mellitus type 2, metabolic encephalopathy, essential (primary) hypertension, osteoarthritis, and prepatellar bursitis. R4's Individual Service Plan dated January 14, 2023, indicated R4 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower	01620		

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01620	Continued From page 25 assistance, dressing assistance, personal cares assistance, toileting assistance, monthly vital signs, change in condition notification to RN, housekeeping, and laundry assistance. R4's record lacked documentation of a physical and cognitive reassessment not to exceed 90 calendar days from the last date of the assessment. R4's ongoing reassessments were completed on August 30, 2022, and February 3, 2023, one-hundred fifty-five days after the required 90-day reassessment date. R5 R5 was admitted March 24, 2022, and had diagnoses to include age-related cognitive decline, pulmonary emphysema, essential (primary) hypertension, cardiac murmur, macular degeneration, and chronic lymphocytic leukemia of B-cell type not having achieved remission. R5's Individual Service Plan dated March 2, 2023, indicated R5 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, personal cares assistance, safety checks, hydration assistance, orientation cueing, monthly vital signs, change in condition notification to RN, housekeeping, and laundry assistance. R5's record lacked documentation of a physical and cognitive reassessment not to exceed 90 calendar days from the last date of the assessment. R5's ongoing reassessments were completed on September 18, 2022, and January 6, 2023, one-hundred eight days after the required 90-day reassessment date. R7	01620		

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01620	Continued From page 26 R7 was admitted August 17, 2022, and had diagnoses to include type 2 diabetes, traumatic subarachnoid hemorrhage without loss of consciousness [brain bleed], and hypertension. R7's Individual Service Plan dated January 20, 2023, indicated R7 received services to include registered nurse (RN) comprehensive assessments, medication management and administration, shower assistance, morning and evening personal cares, dressing and grooming, escorts, toileting assist, housekeeping, and laundry assistance. R7's record lacked documentation of a physical and cognitive reassessment no more than 14-days after initiation of services. R7's initial uniform assessment was completed on August 17, 2022. R7's ongoing reassessment was completed on October 4, 2022, forty-eight days after the required 14-day reassessment date. R7's record lacked documentation of a physical and cognitive reassessment not to exceed 90 calendar days from the last date of the assessment. R7's ongoing reassessment was completed on January 16, 2023, one-hundred and four days after the required 90-day reassessment date. On June 6, 2023, at 8:55 a.m., clinical nurse supervisor (CNS)-D stated, "I had a meeting with the higher ups that this can't be done by one RN. They did open up a position for another full time RN but that was a month ago and so far, we have not gotten anyone. I informed them that I would not be doing any assessments, discharge summaries, or taking admits until I had help because as you have seen I just can't keep up, and that's why all the assessments are late."	01620		

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01620	Continued From page 27 On June 6, 2023, at 11:38 a.m., licensed assisted living director (LALD)-C confirmed the required content listed above was not completed. LALD-C stated, "we are aware of the problem, we are trying to hire more staff, we are trying to catch up, we need to get up to speed, and we have another registered nurse position posted." The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency, dated August 1, 2021, read, "The RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than 90-days d. Change in resident condition" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 28 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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R3, R4, R5, 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 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:	01650		

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01650	Continued From page 29 R3, R4, R5, and R7's service plans lacked the following: - the identification of staff or categories of staff who will provide the services. R3's Individual Service Plan dated March 2, 2023, indicated R3 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, oral care assistance, grooming assistance, escorts, safety checks, change in condition notification to RN, housekeeping, and laundry assistance. R3's Individual Service Plan dated March 2, 2023, lacked the identification of staff or categories of staff who would be providing the following: - oral cares; and - laundry services. R3's Resident Agreement dated January 7, 2023, identified as part of the service plan, lacked the required content noted above. R4 On June 6, 2023, at 7:36 a.m., surveyor observed unlicensed personnel (ULP)-H prepare and administer medications to R4. R4's Individual Service Plan dated January 14, 2023, indicated R4 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, dressing assistance, personal cares assistance, toileting assistance, monthly vital signs, change in condition notification to RN, housekeeping, and laundry assistance. R4's Individual Service Plan dated January 14, 2023, lacked the identification of staff or	01650		

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01650	Continued From page 30 categories of staff who would be providing the following: - personal cares; - dressing; - medication management and administration; and - laundry services. R4's Resident Agreement dated January 4, 2022, identified as a part of the service plan, lacked the required content noted above. R5 R5's Individual Service Plan dated March 2, 2023, indicated R5 received services to include registered nurse (RN) comprehensive assessments, medication administration, shower assistance, personal cares assistance, safety checks, hydration assistance, orientation cueing, monthly vital signs, change in condition notification to RN, housekeeping, and laundry assistance. R5's Individual Service Plan dated March 2, 2023, lacked the identification of staff or categories of staff who would be providing the following: - hydration assistance; - personal cares; - showers as needed; and - laundry services as needed. R5's Resident Agreement dated March 17, 2022, identified as a part of the service plan, lacked the required content noted above. R7's Individual Service Plan dated January 20, 2023, indicated R7 received services to include registered nurse (RN) comprehensive assessments, medication management and administration, shower assistance, morning and	01650		

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01650	Continued From page 31 evening personal cares, dressing and grooming, escorts, toileting assist, housekeeping, and laundry assistance. R7's Individual Service Plan dated January 20, 2023, lacked the identification of staff or categories of staff who would be providing the following: - shower assistance; - medication management and administration; and - laundry services. R7's Resident Agreement dated August 15, 2022, identified as part of the service plan, lacked the required content noted above. On June 6, 2023, at 11:38 a.m., clinical nurse supervisor (CNS)-D confirmed the service plans for R3, R4, R5, and R7 lacked the required content noted above. CNS-D stated he was aware of the problem, had a lot to do, and did not have enough help. Furthermore, CNS-D stated licensee was currently in the process of hiring additional nursing staff. The licensee's Contents of Service Plans policy dated July 28, 2021, lacked language to include the identification of staff or categories of staff who would provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 32 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 medication administration was documented accurately in the medication administration record (MAR) for one of three residents (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 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: R7 was admitted August 17, 2022, and had diagnoses to include type 2 diabetes, traumatic subarachnoid hemorrhage without loss of consciousness [brain bleed], and hypertension.	01760		

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01760	Continued From page 33 R7's service plan dated January 20, 2023, indicated R7 received services which included medication administration. On June 6, 2023, between 8:08 a.m. and 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R7's 8:15 a.m. medications. ULP-B verified on the Electronic Medication Administration Record (EMAR) Hydralazine 50 milligrams (mg), Losartan 50mg, Nifedipine 60mg, and Vitamin D3 25 micrograms (mcg). ULP-B did not verify the daily vitamin, but showed the bottle to the surveyor and stated, "She has these in her room, and she takes them herself" and "She knows her routine so well, she knows when we need to check her blood sugar and when she needs to take her vitamins. So, she keeps those gummy vitamins in here and she takes them right before she goes down for breakfast, so we don't actually give her those we just keep the extra bottle in the cart and give it to her when this bottle goes low. That way she can take the vitamin when she wants to." ULP-B then documented in the EMAR administering all 8:15 a.m. medications including the daily vitamin. On June 7, 2023, at 9:42 a.m., CNS-D stated, "The medications in [R7's] room, I was unaware that was happening. She is not supposed to be doing her own medication administration but apparently family brought the bottle in to her. I was unaware family was bringing them in so I will need to reach out to family and explain why this can't be happening." The licensee's Documentation of Medication, Treatment and Therapy Management Services dated August 1, 2021, indicated documentation for all tasks would be completed immediately after the task had been performed.	01760		

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	35621	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

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01760	Continued From page 34 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for one of nine residents (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 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: R7 admitted for services on August 17, 2022. R7's Medication management plan, completed by an RN on August 17, 2022, indicated R7 would have medication administration provided by	01880		

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	35621	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

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01880	Continued From page 35 agency unlicensed staff. R7's signed Attachment E: Service Plan Agreement, dated January 20, 2023, indicated R7 received medication management and administration services. R7's signed prescriber order dated September 1, 2022, indicated R7 would receive 5 units (u) of Novolog insulin three times a day. MANUFACTURER'S INSTRUCTIONS On January 6, 2023, at 7:33 a.m., the surveyor observed the fourth-floor medication cart to have medications for nine residents, including R7's Novolog insulin pens, one Novolog insulin pen with approximately 80u of insulin and one full Novolog insulin pen with no expiration date label. The manufacturer's guidelines for the use of Novolog insulin pen dated February 1, 2023, indicated unused pens should be refrigerated at 36 degrees to 46 degrees Fahrenheit until first use. MEDICATIONS IN RESIDENT ROOMS On January 6, 2023, at 8:18 a.m., the surveyor observed in R7's apartment, a large over the counter (OTC) bottle of vitafusion women's gummy vitamins with an unknown number of gummies in the bottle, and one sleeve of OTC gas relief capsules containing 12 orange gel capsules. On June 7, 2023, at 9:42 a.m., clinical nurse supervisor (CNS)-D stated, "The medications in [R7's] room I was unaware that was happening. She [R7] is not supposed to be doing her own medication administration but apparently family brought the bottle in to her. I was unaware family	01880		

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GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

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01880	Continued From page 36 was bringing them in so I will need to reach out to family and explain why this can't be happening." The licensees Storage of Medications policy dated July 28, 2021, indicated the registered nurse's (RN) assessment would identify the storage of the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of nine residents (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 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).	01890		

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01890	Continued From page 37 The findings include: On January 6, 2023, at 7:33 a.m., the surveyor observed the fourth-floor medication cart to have medications for nine residents, including R7's Novolog insulin pens, one Novolog insulin pen with approximately 80u of insulin and one full Novolog insulin pen, and one 10 milliliter (ml) bottle of Systane eye drops with no expiration date label. The manufacturer's guidelines for the use of Novolog insulin pen dated February 1, 2023, indicated the NovoLog pen should be thrown away after 28 days from first use, even if it still has insulin in it. The manufacturer's guidelines for the use of Systane eye drops reads, "Do not use our products after they expire. Our expiration labels use international dating, so the year comes first, then the month. Alcon products expire on the last day of the month of the expiration date." On June 6, 2023, at 8:45 a.m., clinical nurse supervisor (CNS)-D observed with surveyor the fourth-floor medication cart and verified the insulin pens and eye drops were not dated. CNS-D stated, "I would be faking a date if I gave you one. I know that you would be expected to date it [time sensitive medications] when you open it, but I would have to look at the policy to see what it says about open dates." The licensees Storage of Medications policy dated July 28, 2021, indicated prescription medications would contain an expiration date of a time-dated drug.	01890		

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01890	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	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 the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1).	01910		

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01910	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was discharged from the licensee to another assisted living facility on April 26, 2023. R1's record lacked a medication disposition to include 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. On June 5, 2023, at 3:30 p.m., Licensed Assisted Living Director (LALD)-C provided surveyors with two documents titled Medication List and printed June 5, 2023, and Packing Slip dated April 21, 2023. These documents lacked to include the quantity of medications sent, date of disposition, and names of staff and other individuals involved in the disposition. On June 5, 2023, at 4:13 p.m., LALD-C stated, "we were able to do a look back from pharmacy information and we have come up with how many of each medication was sent out." On June 6, 2023, at 8:55 a.m., clinical nurse supervisor (CNS)-D stated, "I had a meeting with the higher ups that this can't be done by one	01910		

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01910	Continued From page 40 registered nurse (RN). They did open up a position for another full time RN but that was a month ago and so far, we have not gotten anyone. I informed them that I would not be doing any assessments, discharge summaries, or taking admits until I had help because as you have seen I just can't keep up." The licensee's Disposition or Disposal of Medication policy dated August 1, 2021, indicated "Staff will document the disposition or disposal of medications in the resident's record." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R2, R3) who utilized bed rails. This resulted in issuance of an immediate correction order on June 5, 2023, at approximately 4:00 p.m. This practice resulted in a level three violation (a	02310	On June 7, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of "G".	

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02310	Continued From page 41 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 5, 2023, at 1:40 p.m., the surveyor observed bilateral half bedrails on the upper sides of R2's and R3's hospital beds in the raised position. At the time of observation, R2 required staff assistance with bed mobility, and R3 required physical assistance of one to get in and out of bed. At the time of surveyor observation, R3 was asleep in a supine position on R3's hospital bed. R2's diagnoses include vascular dementia without behavioral disturbances, cerebral infarction, unspecified fracture of shaft of right femur, and age-related osteoporosis. R3's diagnosis included unspecified dementia. On June 5, 2023, at 1:50 p.m., clinical nurse supervisor (CNS)-D verified R2 had received bedrails on May 30, 2023, and R3 received bedrails approximately May 18, 2023. CNS-D verified the bedrails had not been assessed for safety with measurements, nor was the education provided to the resident/resident representative on the risks associated with bed rail use documented. CNS-D further stated, he was aware of the requirements for bed rail assessments. CNS-D stated he had not gotten around to getting the bed rail assessments	02310		

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02310	Continued From page 42 completed. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *06/05/23*
Time: 11:30:00
Report: 1031231147

Food and Beverage Establishment Inspection Report

Location:

Global Pointe Senior Living
5200 Wayzata Boulevard
Golden Valley, MN55416
Hennepin County, 27

Establishment Info:

ID #: 0039126
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632858729
ID #:

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

No NEW orders were issued during this inspection.

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

Facility is staffed by a 3rd party - Compass.

Information has been passed on to appropriate jurisdiction for licensing.

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

I acknowledge receipt of the Environmental Health inspection report number 1031231147 of 06/05/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jana Henry
Person in Charge

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