



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 26, 2025

Licensee
Golden Hearts Inc
602 Marion Drive
Arlington, MN 55307

RE: Project Number(s) SL38174016

Dear Licensee:

On November 25, 2025, 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 August 28, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 28, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 28, 2025, found not corrected at the time of the November 25, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 25, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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,



Tim Hanna, Supervisor

State Evaluation Team

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38174016-1 On November 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 28, 2025. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			

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{0 680}	Continued From page 3	{0 680}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{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}	Not reviewed during this survey.		

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{0 730}	Continued From page 4 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 5 (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:	{0 730}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 24, 2025, the surveyor initiated a follow-up for a survey conducted on August 28, 2025. Surveyor entered the facility at 9:15 a.m. and was met by licensed assisted living director (LALD)-A.	{0 775}			

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{0 775}	Continued From page 6 During facility tour on November 24, 2025, from 9:24 a.m. through 9:49 a.m., with (LALD)-A the surveyor observed an inspection tag dated March 2023 on the fire alarm panel. LALD-A stated that they have not had the fire alarm system inspected and tested but they have contacted a company to complete the testing and inspection. LALD-A stated they would email confirmation of the inspection date. State Fire Code in Minnesota Rules, chapter 7511 requires fire alarm systems be inspected and tested at least annually. LALD-A verified the above findings while accompanying on the tour and stated they understood the requirement.	{0 775}			
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	{01470}			

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{01470}	Continued From page 7 support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01470}			

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{01470}	Continued From page 8		{01470}	Not reviewed during this survey.	
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the		{01530}		

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{01530}	Continued From page 9 requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{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 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;	{01650}			

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{01650}	Continued From page 10 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:	{01650}	Not reviewed during this survey.		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	{01730}			

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{01730}	Continued From page 11 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}			
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	{01770}	Not reviewed during this survey.		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	{01890}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01890}	Continued From page 12 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}	Not reviewed during this survey.		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}			
{02110} SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	{02110}			

Minnesota Department of Health

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{02110}	Continued From page 13 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by:	{02110}			
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	{02170}	Not reviewed during this survey.		

Minnesota Department of Health

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{02170}	Continued From page 14 addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}	Not reviewed during this survey.		

Minnesota Department of Health

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{02320}	Continued From page 15	{02320}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}			
			Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 8, 2025

Licensee
Golden Hearts Inc
602 Marion Drive
Arlington, MN 55307

RE: Project Number(s) SL38174016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307			
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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: SL38174016 On August 25, 2025, through August 28, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on August 28, 2025, issued for SL38174016-0, tag identification 0775.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of one unlicensed personnel (ULP-C). This had the potential to affect all residents, visitors, and staff. 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	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: On August 24, 2025, the surveyor observed the following: -at 8:50 a.m., ULP-C prepared butter toast with jelly without wearing gloves; and -at 9:31 a.m., ULP-C prepared butter toast with jelly and cut a peach without wearing gloves. ULP-C did not use proper hygiene and infection control techniques with food preparation. On August 26, 2025, at 11:05 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-E stated when food prep is being completed, staff were trained to wear gloves. On August 26, 2025, at 11:30 a.m., ULP-C stated she was trained to wear gloves while handling food and did not follow policy. The licensee's Glove Use policy dated January 1, 2025, indicated gloves are worn to prevent bare hand contact with ready to eat food and preparation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680			

Minnesota Department of Health

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0 680	Continued From page 5 (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 develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680			

Minnesota Department of Health

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0 680	Continued From page 6 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 25, 2025, at 12:02 p.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's EPP plan lacked evidence of the following required content: - missing resident quarterly review; - arrangement with other facilities; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; and - emergency prep training program. On August 27, 2025, at 3:58 p.m., licensed assisted living director (LALD)-A and housing manager (HM)-E reviewed the emergency preparedness binder and stated the above required content was not able to be located. The licensee's Emergency and Disaster Preparedness policy dated January 1, 2025, indicated the emergency preparedness plan would include the above lacked information. 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	0 730			

Minnesota Department of Health

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0 730	Continued From page 7 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 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;	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 8 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included the required documentation of all provided services for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on March 31, 2025, with diagnoses that included diabetes and dementia. R2's service plan dated March 31, 2025, indicated R2 received services to include assistance with dressing, bathing, personal hygiene, and toileting. R2's record lacked documentation of the	0 730			

Minnesota Department of Health

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0 730	Continued From page 9 following services provided: -bathing; -dressing; -personal hygiene; and -toileting R3 R3 was admitted on October 25, 2022, with diagnosis that included a cerebrovascular accident (stroke). R3's service plan dated February 10, 2025, indicated R3 received services to include assistance with mobility, compression stockings, dressing, bathing, and hygiene/grooming. R3's record lacked documentation of the following services provided: -mobility; -compression stockings; -dressing; -bathing; and -hygiene/grooming. On August 27, 2025, at 1:01 p.m., licensed assisted living director (LALD)-A stated R2 and R3's record lacked documentation of the services provided as listed above. LALD-A stated staff do not document in the electronic medical record for current residents; rather, they document daily tasks on a calendar hanging in the kitchen. The licensee's Resident Record policy, undated, indicated the resident record would contain documentation that services have been provided as identified in the service plan. No further information was provided.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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0 730	Continued From page 10	0 730			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on August 28, 2025, from 11:09 a.m. through 11:55 a.m. with licensed assisted living director (LALD)-A, it was observed that compliant emergency escape and rescue openings were not provided in occupied resident rooms one, two, ten, and unoccupied resident room nine. LALD-A and the surveyor entered resident rooms one, two, nine and ten. LALD-A opened the windows for measurement. Emergency escape	0 775			

Minnesota Department of Health

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0 775	Continued From page 11 and rescue clear window opening measurements were 24 inches wide, 17 inches in height and 408 square inches in openable area. The windows were measured with LALD-A, and the surveyor. The windows did not meet the minimum requirements for clear opening height and clear opening area. During the tour LALD-A stated that the window in occupied resident room three was the same style and size as resident room two. State Fire Code in Minnesota Rules, chapter 7511 requires at least one compliant emergency escape and rescue opening within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. During same tour the surveyor observed locked exit doors throughout the facility that required a code to unlock. LALD-A stated that the doors would unlock upon activation of the fire alarms but was unsure if there was a switch to deactivate the locks. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. Locked exits must unlock with activation of the fire alarm system and be capable of being deactivated at an approved location. During same tour the surveyor observed an inspection tag dated March 2023 on the fire	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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0 775	Continued From page 12 alarm panel. LALD-A stated they were unsure if there was a more recent inspection tag. During an interview on August 28, 2025, at 12:43 p.m. with LALD-A the surveyor requested a copy of the annual fire alarm testing and inspection report. LALD-A provided the surveyor a copy of the kitchen hood fire suppression report. LALD-A stated that was all they could find and was unsure if the system had been inspected since that time, other than by facility staff. State Fire Code in Minnesota Rules, chapter 7511 requires fire alarm systems be inspected and tested at least annually. LALD-A visually verified the above findings while accompanying on the tour and stated they understood the requirement. TIME PERIOD FOR CORRECTION: Immediate.	0 775			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

Minnesota Department of Health

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01470	Continued From page 13 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

Minnesota Department of Health

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01470	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on September 17, 2009, to provide direct care and services to the facility's residents. On August 27, 2025, at 10:15 a.m., the surveyor observed ULP-C administer R3's morning medications. ULP-C's employee record did not include the following required orientation content: -Overview of Assisted Living statutes -Review of provider's policies and procedures -Handling emergencies and using emergency services -Reporting maltreatment of vulnerable adults or	01470			

Minnesota Department of Health

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01470	Continued From page 15 minors -Assisted Living Bill of Rights -Handing of resident complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery On August 25, 2024, at 4:08 p.m. licensed assisted living director (LALD)-A stated ULP-C had not completed all components of the required orientation training for assisted living facilities. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - ALL Staff policy dated January 1, 2025, indicated newly hired staff will receive orientation and training on topics required for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530			

Minnesota Department of Health

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01530	Continued From page 16 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C)	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01530	Continued From page 17 received the required amount of annual dementia care training and required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility held an assisted living with dementia care license. ULP-C was hired on September 17, 2009, to provide direct care services to the facility's residents. On August 27, 2025, at 10:15 a.m., the surveyor observed ULP-C administer R3's morning medications. ULP-C's employee record lacked documented evidence of the following required training: - at least two hours of training on topics related to dementia care for each 12 months of employment; and - at least two hours completed training in mental illness or de-escalation by July 1, 2025. On August 25, 2025, at 4:08 p.m., licensed assisted living director (LALD)-A stated the required training had not been completed by	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01530	Continued From page 18 ULP-C. The licensee's Assisted Living with Memory Care Dementia Training policy dated January 1, 2025, indicated assisted living staff will receive required training on dementia care annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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 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	01650			

Minnesota Department of Health

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01650	Continued From page 19 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 three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 started receiving services on March 31, 2025, with diagnoses that included dementia and diabetes. R2's service plan dated March 31, 2025, indicated R2 received services to include assistance with medication management, dressing, bathing, personal hygiene, blood glucose, toileting, housekeeping, and laundry. On August 27, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-C apply R2's Dexcom sensor (measures glucose level).	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01650	Continued From page 20 R3 R3 was admitted on October 25, 2022, with diagnosis that included a cerebrovascular accident (stroke). R3's service plan dated February 10, 2025, indicated R3 received services to include assistance with mobility, compression stockings, medication management, dressing, bathing, hygiene/grooming, housekeeping, and laundry. On August 27, 2025, at 10:15 a.m., the surveyor observed ULP-C administer R3's morning medications. R4 R4 was admitted on March 1, 2024, with diagnosis that included dementia. R4's service plan dated January 27, 2025, indicated R4 received services to include assistance with mobility, toileting, medication management, dressing, bathing, hygiene/grooming, housekeeping, and laundry. On August 27, 2025, at 10:29 a.m., the surveyor observed ULP-C administer R4's morning medications. R2, R3, and R4's service plan lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - methods of monitoring staff providing home care services; and - a contingency plan that includes: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01650	Continued From page 21 by the resident under those chapters. On August 26, 2024, at 4:16 p.m., licensed assisted living director (LALD)-A and housing manager (HM)-E service plan had not been developed to include the above required content, stating it was missed. LALD-A further stated all the current licensee's residents would be missing the same information. The licensee's Contents of Service Plans policy dated January 1, 2025, indicated the service plan would include: - the schedule and methods of monitoring assessments of the resident; - methods of monitoring staff providing home care services; and - a contingency plan that includes: - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01730	Continued From page 22 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01730	Continued From page 23 Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 started receiving services on March 31, 2025, with diagnoses that included dementia and diabetes. R2's service plan dated March 31, 2025, indicated R2's services included medication administration. On August 26, 2025, at 9:56 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning insulin. R2's provider orders dated August 12, 2025, included an order for Soliqua 100 unit-33 mcg/ml (microgram/milliliter) give 50 units under the skin once daily. R4 R4 was admitted on March 1, 2024, with	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307			
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01730	Continued From page 24 diagnosis that included dementia. R4's service plan dated January 27, 2025, indicated R4's services included medication administration. On August 27, 2025, at 10:29 a.m., the surveyor observed ULP-C administer R4's morning medications. R4's provider orders dated August 18, 2025, included an order for Gabapentin 200 milligrams (mg) by mouth mid morning, supper, and bed time. R2 and R4's record lacked a medication management plan to include: - type of medication storage system, based on resident's needs; and - the procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On August 27, 2025, at 1:01 p.m., licensed assisted living director (LALD)-A stated R2 and R4's medication management plan was missing the above information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01770	Continued From page 25 administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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 the residents). The findings include: During the entrance conference on August 25, 2025, at 12:02 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents. R3 was admitted on October 25, 2022, with diagnosis that included a cerebrovascular accident (stroke). R3's Service Plan dated February 10, 2025, indicated R3's services included medication administration. R3's medication administration record (MAR) dated between August 1, 2025, and August 26, 2025, indicated R3 received the following	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01770	Continued From page 26 medications: -aspirin chewable 81 milligram (mg), take one tablet by mouth daily -beef organs, take 5 capsules by mouth daily -collagen powder, 1 scoop by mouth twice daily (self-administers) -digestive enzymes, 2 capsules by mouth three times daily -melatonin 3 mg, by mouth at bedtime -methyl B-12 1,000 microgram (mcg), by mouth daily -MSM (methylsulfonmethane) ½ teaspoon (tsp), by mouth twice daily (self-administers) -multivitamin powder 1 scoop, by mouth twice daily (self-administers) -neprinol 1 capsule, by mouth three times daily -probiotic solution 100+ 2 tsp, by mouth daily (self-administers) -probiotics-mannaflora 3 tsp in 2 ounces of water, by mouth daily -vitamin D3 1,000 international units (IU), by mouth daily -warfarin 6 mg, by mouth every Tuesday, Thursday, and Sunday -warfarin 4 mg, by mouth every Monday, Wednesday, Friday, and Saturday On August 26, 2025, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-C take medications from a preset pill box and administer the oral medications to R3. R3's record lacked documentation of the dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On August 27, 2025, at 3:07 p.m., licensed	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01770	Continued From page 27 assisted living director (LALD)-A stated CNS-B completed medication set ups for residents at the facility; however, CNS-D was not aware of the required documentation for the medication set ups. The licensee's Delegation of Nursing Tasks Documentation of Medication Setup policy dated January 1, 2025, indicated set-up medications in medi-minders would be completed weekly and as needed. Contents of medi-minders will be documented as to name of medication, number of medication and number of days. Documentation will be under individualized name, profile, medication, then sign review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R2). This practice resulted in a level two violation (a	01890			

Minnesota Department of Health

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01890	Continued From page 28 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on March 31, 2025, with diagnoses that included diabetes and dementia. R2's provider's orders dated August 12, 2025, included an order for Soliqua 100-33 unit-microgram/milliliter (U-mcg/ml) solution pen; inject 50 units under the skin once daily. On August 26, 2025, at 9:56 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning insulin which included an undated, opened Soliqua insulin pen. ULP-C verified the opened insulin pen did not have an open date on the package. On August 26, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated all time sensitive medications should be dated when opened. The manufacturer instructions for Soliqua 100/33 U-mcg/ml dated June 24, 2025, directed a used pen should be discarded after 28 days, even if there is still medicine remaining. The licensee's Storage of Medication policy dated January 1, 2025, indicated the medication label must include the expiration date of time-dated drugs.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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01890	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01960			

Minnesota Department of Health

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01960	Continued From page 30 The findings include: R2 was admitted on March 31, 2025, with diagnoses that included diabetes and dementia. R2's provider orders dated August 5, 2025, included: - blood glucose check three times daily R2's treatment administration record (TAR) dated August 2025, included blood glucose check every morning before administration of insulin. The TAR did not include blood glucose check three times daily. On August 27, 2025, at 3:07 p.m., licensed assisted living director (LALD)-A stated staff are checking once daily blood glucose. LALD-A would confer with the clinical nurse supervisor and update the TAR with the current order of blood glucose check three times daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;	02110			

Minnesota Department of Health

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02110	Continued From page 31 (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that will cause only minimal impact on	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02110	Continued From page 32 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: R2, R3 and R4's records lacked evidence R2, R3, and R4's legal and designated representative were provided the licensee's policies and procedures related to assisted living with dementia care as required. R2 R2 was admitted on March 31, 2025, with diagnoses that included diabetes and dementia. R2's service plan dated March 31, 2025, indicated R2 received services to include assistance with medication management, dressing, bathing, personal hygiene, blood glucose, toileting, housekeeping, and laundry. On August 27, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-C apply R2's Dexcom sensor (measures glucose level). R3 R3 was admitted on October 25, 2022, with diagnosis that included a cerebrovascular accident (stroke). R3's service plan dated February 10, 2025, indicated R3 received services to include assistance with mobility, compression stockings, medication management, dressing, bathing, hygiene/grooming, housekeeping, and laundry.	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02110	Continued From page 33 On August 27, 2025, at 10:15 a.m., the surveyor observed ULP-C administer R3's morning medications. R4 R4 was admitted on March 1, 2024, with diagnosis that included dementia. R4's service plan dated January 27, 2025, indicated R4 received services to include assistance with mobility, toileting, medication management, dressing, bathing, hygiene/grooming, housekeeping, and laundry. On August 27, 2025, at 10:29 a.m., the surveyor observed ULP-C administer R4's morning medications. On August 27, 2025, at 3:58 p.m., licensed assisted living director (LALD)-A and housing manager (HM)-E stated the required policies and procedures had not been provided to R2, R3 and R4's legal and/or designated representative at time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills;	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02170	Continued From page 34 (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R2) with dementia.	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02170	Continued From page 35 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 provider had an Assisted Living with Dementia Care license effective September 14, 2024. R2 R2 was admitted on March 31, 2025, with diagnoses that included diabetes and dementia. R2's service plan dated March 31, 2025, indicated R2 received services to include assistance with medication management, dressing, bathing, personal hygiene, blood glucose, toileting, housekeeping, and laundry. R2's records lacked an individualized written activity evaluation that addressed: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan based on the	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02170	Continued From page 36 activity evaluation. On August 27, 2025, at 3:27 p.m., licensed assisted living director (LALD)-A stated R2's record lacked the above required components. LALD-A further stated none of the residents had an activity plan based on the evaluation. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC policy, dated January 1, 2025, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: -past and current interest -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions An individualized activity plan must be developed for each resident based on their activity evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 602 MARION DRIVE ARLINGTON, MN 55307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 37 sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were set-up according to policy and accepted standards of practice for one of two residents (R4). 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: R4 was admitted on March 1, 2024, with diagnosis that included dementia. R4's service plan dated January 27, 2025, indicated R4 received services to include assistance with mobility, toileting, medication management, dressing, bathing, hygiene/grooming, housekeeping, and laundry. R4's record included a prescriber order dated August 18, 2025, for gabapentin 200 milligram (mg) at mid-morning, supper, and bedtime. On August 27, 2025, at 10:29 a.m., the surveyor observed unlicensed personnel (ULP)-C	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2025
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02320	Continued From page 38 administer R4's morning medications that included pre-set up gabapentin 100 mg: 2 capsules. The surveyor asked ULP-C who completed the pre-set gabapentin and ULP-C stated the housing manager (HM)-E. On August 27, 2025, at 11:05 a.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-E stated the order for gabapentin was a changed dose and CNS-B instructed ULP-C to set up the medication in a pre-set-up medication caddie over the phone. According to MN Statute 144G.08, Subd. 41 Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident of by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

GOLDEN HEARTS INC
602 MARION DRIVE
Arlington, MN 55307
Sibley County
Parcel:

Phone:

License Info

License: HFID 38174

Risk:
License:
Expires on:
CFPM: Larry Gene Kicker
CFPM #: 35412; Exp: 4/9/2028

Inspection Info

Report Number: F1033251153
Inspection Type: Full - Single
Date: 8/26/2025 Time: 10:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: Emailed

New Order: 2-400 Hygienic Practices

2-401.11B Priority Level: Priority 3 CFP#: 6

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

COMMENT: Employee beverage without a cover is stored on the counter in the kitchen. Person in charge provided a cover and moved the beverage.

Comply By: Complied On Site Originally Issued On: 8/26/2025

! New Order: 3-200A Food Characteristics: approved source

3-201.11B Priority Level: Priority 1 CFP#: 11

MN Rule 4626.0130B Remove all foods that were prepared or stored in a private home from the premises, except as allowed in Minnesota Statutes 28A.15 and 157.22 clauses 6 and 7.

COMMENT: Facility is serving residents house hold prepared canned items.

Comply By: 8/26/2025 Originally Issued On: 8/26/2025

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

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

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

COMMENT: Raw shelled eggs stored above ready to eat items in the upright refrigerator.

Comply By: 8/26/2025 Originally Issued On: 8/26/2025

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

3-302.11A(4) Priority Level: Priority 3 CFP#: 15

MN Rule 4626.0235A(4) Protect food from cross-contamination by packages or covered containers.

COMMENT: Pet food is stored in the dry storage room on top of human food. Person in charge removed pet food.

Comply By: Complied On Site Originally Issued On: 8/26/2025

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

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

COMMENT: Facility is cooking hamburgers on household griddles.

Comply By: 8/26/2025 Originally Issued On: 8/26/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: Facility does not have a quaternary ammonium test kit.

Comply By: 9/5/2025 Originally Issued On: 8/26/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.12 *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

COMMENT: Cutting boards are in poor condition. Person in charge discarded cutting boards.

Comply By: Complied On Site Originally Issued On: 8/26/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.19CMN *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0780C Discontinue the use of a food preparation sink for anything other than food preparation.

COMMENT: Employee rinsing dishes in the food preparation sink.

Comply By: 8/26/2025 Originally Issued On: 8/26/2025

! New Order: 5-200B Plumbing: cross connections

5-203.14A *Priority Level: Priority 1 CFP#: 51*

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

COMMENT: Water softener drain tube is stored below the flood level of the mop sink.

Comply By: 8/26/2025 Originally Issued On: 8/26/2025

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

I acknowledge receipt of the Mankato District Office inspection report number F1033251153 from 8/26/2025

Establishment Representative

Isaiah Armendariz

Isaiah Armendariz,
Public Health Sanitarian 2
507-344-2743
isaiah.armendariz@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
GOLDEN HEARTS INC	Report Number: F1033251153
Arlington	Inspection Type: Full
County/Group: Sibley County	Date: 8/26/2025
	Time: 10:00 AM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Ambient Air

Location: Upright Freezer at 0> Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese Slices; Temperature Process: Cold-Holding

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Storage Room; Temperature Process: Ambient Air

Location: Upright Freezer at 0> Degrees F.

Comment:

Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
GOLDEN HEARTS INC	Report Number: F1033251153
Arlington	Inspection Type: Full
County/Group: Sibley County	Date: 8/26/2025
	Time: 10:00 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Spray Bottle

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 170 Degrees F.

Comment:

Violation Issued?: No