DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 13, 2024

Licensee
Golden Pond Champlin
6708 119th Place North
Champlin, MN 55316

RE: Project Number(s) SL31077015

Dear Licensee:

On October 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 18, 2024

Licensee
Golden Pond Champlin
6708 119th Place North
Champlin, MN 55316

RE: Project Number(s) SL31077015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 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

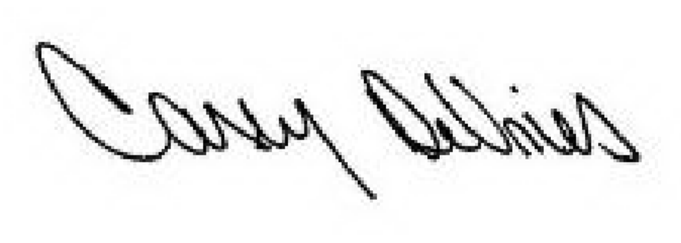
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31077015-0 On August 5, 2024, through August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; three of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 2 (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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 12:46 p.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-C assist R3 with changing and repositioning. ULP-B and ULP-C each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. While R3 was lying on her back, ULP-C unfastened the side tapes holding the incontinence brief in place. ULP-B held R3's legs	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 3 apart at her knees while ULP-C pushed the front of the soiled brief between R3's legs onto the bed. ULP-C used a spray bottle of perineal area cleanser and sprayed the cleanser directly onto R3's exposed skin. ULP-C then used pre-moistened wipes to clean the area and wipe the cleanser away. When R3's front was clean, ULP-B rolled R3 toward them. ULP-C sprayed the perineal cleanser on R3's lower back, buttocks, and upper legs where they had visible bowel movement, then ULP-C used the pre-moistened wipes. ULP-C removed the soiled brief from underneath R3 and placed it in the garbage at the foot of the bed. ULP-C then removed their gloves, put on a new pair of gloves, applied barrier cream to R3's buttocks, removed gloves again, and put on new gloves without performing hand hygiene between either of the glove changes. ULP-B and ULP-C then turned R3 back and forth to get a clean brief pulled up in front and taped at sides, and again to get a lift sheet placed under R3. ULP-B removed the soiled under pad from beneath R3, placed the under pad in the garbage at the end of the bed, and left their same gloves on. The ULPs used the ceiling lift to raise R3 off the bed, smooth out her sheets, place clean disposable under pads, and raise R3 closer to the head of the bed. The ULPs worked together to position a pillow behind each of R3's shoulders, one between her knees, a wedge under her legs to keep her heels elevated off the bed. At 1:02 p.m., ULP-B and ULP-C removed their gloves, left R3's room, and washed their hands in the kitchen. On August 7, 2024, at 12:19 p.m., the surveyor observed ULP-E and ULP-F assist R3 with changing and repositioning. ULP-E and ULP-F each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. The	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 4 ULPs untaped the sides of the soiled brief and pulled it down in front. ULP-F used peri area cleanser spray and pre-moistened wet wipes to clean R3's peri area. After rolling R3 onto their right side, ULP-F used the spray cleanser and wipes on R3's low back and buttocks to clean visible bowel movement from the skin, and then tucked the soiled brief under R3. ULP-F used the same gloves they had on to tuck the clean brief under R3. Then the ULP's rolled R3 back over onto R3's left side. ULP-E removed the soiled brief and used spray cleanser and wipes to clean right side of back and buttocks that ULP-F could not reach from other side. ULP-E applied barrier cream to R3's buttocks, removed gloves, and put on a clean gloves without performing hand hygiene. The ULPs rolled R3 back onto their back, pulled up middle of brief, and taped the sides. There was also some bowel movement on R3's shirt the ULPs had noticed when changing the brief. ULP-F got a clean shirt out of the closet with same gloves on. The ULPs removed R3's shirt and put it in the laundry basket in R3's room. The ULPs assisted R3's arms into the clean shirt, pulled it over R3's head, then rolled R3 back and forth to pull the back of shirt down so it was smooth and on appropriately. The ULPs moved R3 up in bed using the draw sheet to pull them up toward the head of the bed. The ULP's then fixed the pillow under R3's head to look more comfortable, placed pillows under R3's right and left shoulders, between their knees, the wedge under their feet, and put the blanket on. ULP-E took the garbage out of the room and returned with gloves off. ULP-F removed their gloves and washed their hands in R3's bathroom. ULP-E put one glove back on, picked up a soiled cloth pad that had been left on the floor, and put the pad in the laundry basket. ULP-E removed their gloves and washed their hands in R3's bathroom before	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 5 exiting the room. On August 6, 2024, at 2:31 p.m., ULP-B stated they had been trained on handwashing by licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. ULP-B stated they had been trained to wash their hands upon arrival for a shift, at the end of a shift, before any cares, after cares, before cooking, before putting gloves on, and after removing gloves. ULP-B agreed hand hygiene should be performed when changing gloves during cares for the same resident as that was still removing and applying gloves. On August 7, 2024, at 12:10 p.m., ULP-E stated they had been trained on handwashing by LALD/CNS-A. ULP-E stated they would wash their hands before and after any cares, and before and after medication administration. On August 7, 2024, at 2:25 p.m., via telephone interview, ULP-C stated they received handwashing training from LALD/CNS-A. ULP-C stated they wash their hands at the beginning of their shift, before and after everything, and before putting gloves on and after removing gloves. The surveyor asked if employees should perform hand hygiene in between glove changes when cares with one resident necessitated multiple glove changes. ULP-C stated "yes, you should". On August 7, 2024, at 1:15 p.m., LALD/CNS-A stated staff received training on hand hygiene and infection control during online education modules, during training and competency with nursing, and during direct supervision at the facility. LALD/CNS-A stated they expected ULPs to wash hands before preparing food, medications, putting gloves on, after removing gloves, and after any	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 6 cares. LALD/CNS-A stated ULPs should wash their hands or use hand sanitizer during complex cares that involve multiple gloves changes each time gloves are removed and before new gloves are put on. The Center of Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, recommended hand hygiene to be performed immediately before touching a patient (resident), before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient (resident), after touching a patient (resident) or patient's (resident's) surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. The CDC indicated gloves are not a substitute for hand hygiene and recommended performing hand hygiene before donning gloves and touching the patient (resident) or the patient's (resident's) surroundings, always clean hands after removing gloves, and to remove gloves carefully to prevent hand contamination as dirty gloves can soil hands. The CDC recommended changing gloves and performing hand hygiene if gloves become damaged, if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient (resident), if a clinical indication for hand hygiene occurs, if moving from care on one patient (resident) to another patient (resident), if the gloves look dirty or have blood or body fluids on them after completing a task, and before exiting a patient (resident) room. The licensee's Infection Control policy, dated August 1, 2021, indicated handwashing should be	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 510	Continued From page 7 performed: - before, during, and after preparing food; - before eating food; - before and after caring for someone who is sick; - before and after treating a cut or wound; - after using the toilet; - after changing diapers or cleaning up after someone who has used the toilet; - after blowing your nose, coughing, or sneezing; - after touching an animal or animal waste; - after handling pet food or pet treats; and - after touching garbage. In addition, when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 650	Continued From page 8 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content of training and competency for younkers mouth suctioning for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B had a hire date of September 30, 2015. ULP-B provided direct services to residents. On August 5, 2024, at 1:08 p.m., the surveyor observed ULP-B assisting R3 with eating lunch in R3's room. R3 frequently coughed and gagged during the meal. When this happened, ULP-B used younkers suction to clear R3's mouth. ULP-B stated R3 required suction multiple times while eating meals and at night. ULP-B stated R3 choked on saliva during night and when that	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 650	Continued From page 9 happened ULPs provided younkers suction for her mouth urgently. On August 6, 2024, at 1:50 p.m., LALD/CNS-A stated they sent videos to staff for training on younker's suction for R3 either from the manufacturer's website or elsewhere from the internet. LALD/CNS-A stated they met with employees on site for training after they had watched the videos. During that training, LALD/CNS-A demonstrated the suction procedure, how to clean, order supplies, and change the tubing. LALD/CNS-A stated they used the manufacturer manual for training and information on how to use the machine. LALD/CNS-A stated they had employees demonstrate back the suction procedure while LALD/CNS-A was onsite with them at the facility. LALD/CNS-A stated they did not have any written training, checklist, or competency completed during training and were not able to provide any tracking measurement of who had been trained. LALD/CNS-A stated they believed they had trained all staff that work at the facility. On August 6, 2024, at 2:31 p.m., ULP-B stated they received training from LALD/CNS-A when R3 first got the suction machine. ULP-B stated they remembered coming into the facility for an all-staff training with LALD/CNS-A. ULP-B stated LALD/CNS-A demonstrated the suction, cleaning, and changing the tubing. ULP-B stated LALD/CNS-A observed each employee perform suctioning one by one when they were working. The licensee's Employee Records policy, dated August 1, 2021, indicated licensee would maintain an up to date and confidential record for all employees. The record would contain records of all training and in-service education required	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 650	Continued From page 10 and/ or provided including record of competency testing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include TB testing upon hire for one of two employees (licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A).	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 660	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 TB risk assessment was completed September 5, 2023, and indicated the facility was at a low risk for TB transmission. LALD/CNS-A was hired on September 25, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. LALD/CNS-A's employee record included completed baseline and annual health history and symptom screenings, record of annual TB training, and chest x-ray results, dated October 4, 1999, and July 1, 2022. LALD/CNS- A's record lacked baseline TB testing completed on or within ninety days prior to their hire date with licensee. LALD/CNS-A's record did not include any historical positive TB testing results that would indicate appropriateness of chest x-rays for monitoring. On August 6, 2024, at 3:53 p.m., LALD/CNS-A stated they had a positive TB skin test in the past but was unsure how long ago, where it was completed, and did not believe they had any record of it. LALD/CNS-A stated they had gotten chest x-rays instead of other testing for "many years".	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 660	Continued From page 12 On August 6, 2024, at 4:02 p.m., chief executive officer (CEO)-D stated if a new hire told them they had a history of positive TB testing in the past and wanted a chest x-ray instead, CEO-D would ask to see the positive result. CEO-D stated if the employee was not able to provide the positive result, they would have them do a skin test or blood test to have a record of positive result. CEO-D stated they would then move on to chest x-ray and forward from there depending on the result of the skin or blood test. CEO-D stated they had not required the registered nurses employed by the company to provide a positive TB testing history because the RNs were also working in hospitals and had passed their screening there. CEO-D stated based on that, they thought it was adequate for the RN group of employees not to have the record of positive test. The licensee's Infection Control policy, dated August 1, 2021, indicated all staff who worked within the same air space of residents would be screened and tested for tuberculosis prior to the staff being exposed to residents. If an employee has a history of a positive test result, they must provide dates of testing, test results, current assessment for TB symptoms, and chest x-ray completed no more than three months prior to the positive result or after the date of the positive result. If the employee is unable to provide this documentation, they must complete TB skin testing or TB blood test prior to working within the same air space of residents. Regulations for Tuberculosis Control in Minnesota Health Care Settings: A guide for implementing tuberculosis infection control regulations in your facility, dated July 2013, indicated before the health care worker (HCW) has direct patient	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 660	Continued From page 13 contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and 4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 680	Continued From page 14 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living facility license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at 12:00 p.m., licensed	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 680	Continued From page 15 assisted living director/ clinical nurse supervisor (LALD/CNS)-A provided the surveyor with a lime green binder and stated the binder contained the the facility's entire, current EPP. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policies/procedures (P/P) for ensuring medical supplies and pharmaceutical supplies; - P/P to address role of facility under a waiver declared by the Secretary; - written communication plan that included names and contact information of staff, entities providing services under agreement, residents' physicians, other facilities, volunteers, Federal, State, tribal, regional and local emergency staff, State Licensing and Certification Agency, the MN Office of Ombudsman for LTC; - written training and testing program of EPP; and - conduct exercises to test the EPP at least twice per year. On August 5, 2021, at 4:21 p.m., the surveyor sent an email to LALD/CNS-A and chief executive officer (CEO)-D requesting the hazard vulnerability assessment (HVA) and communication plan as they were not present in the EPP binder onsite at the facility. On August 5, 2021, at 5:14 p.m., via telephone interview, CEO-D stated the HVA, and communication plan should have been in the binder, but CEO-D would email them to the surveyor. On August 6, 2024, at 10:50 a.m., CEO-D	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 680	Continued From page 16 emailed the surveyor an attachment titled emergency plan Champlin. The attachment contained updated EPP documents that were different than the documents in the facility EPP binder. On August 6, 2024, at 4:02 p.m., via Facetime interview, CEO-D stated the company had updated their EPP for each facility in response to citations at other facilities within their company. CEO-D stated the EPP onsite should be a new version in a red binder. CEO-D stated the lime green binder on site was not current. On August 6, 2024, at 4:45 p.m., LALD/CNS-A confirmed the lime green binder provided to the surveyor was the current EPP for facility. LALD/CNS-A was not aware of another binder that had been brought to the facility and was not able to locate one. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated licensee would effectively respond to, report, and review all emergencies to ensure the safety of residents receiving services and to promote the continuity of services until emergencies are resolved. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 790	Continued From page 17 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 6, 2024, from 2:15 p.m. to 3:00 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-C, it was observed that the required fire extinguisher located at the main entrance had a service tag installed with a date of last service in October 2022. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 790	Continued From page 18 within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During a facility tour on August 6, 2024, at 2:30 p.m., LALD/CNS-A, and ULP-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 800	Continued From page 19 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 potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 6, 2024, from 2:15 p.m. to 3:00 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-C, the surveyor made the following observations of facility hazard or disrepair: The door leading from the occupied space of the assisted living to the attached garage was marked with an exit sign. The garage space shall not be marked and used as an exit route from the occupied assisted living as the garage is a higher hazard area in accordance with current Minnesota Fire Code. The fire evacuation floor plan indicated a primary exit route directing occupants of the assisted living through the attached garage as an exit. The garage space shall not be marked and used as an exit route from the occupied assisted living as the garage is a higher hazard area in accordance with current Minnesota Fire Code. There was corrugated plastic and clear plastic wall finish material installed on the walls to a height of 4 feet from the floor in the main	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 800	Continued From page 20 common traffic area (exit routes) and in resident rooms. Wall finishes are required to meet surface burning and development of smoke characteristics in accordance with current Minnesota Fire Code. During a facility tour on August 6, 2024, at 3:00 p.m., LALD/CNS-A, and ULP-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 21 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 3:00 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 22 The licensee provided FSEP undated, failed to include the following: The available FSEP included resident evacuation status and unique needs for evacuation for each individual resident, but the documentation was located in an electronic file and not available with the FSEP for use at all times within the facility during a fire or similar emergency. During an interview on August 6, 2024, at 3:25 p.m., LALD/CNS-A, stated the evacuation status and unique needs for evacuation for each individual resident was located in an electronic file and not available with the FSEP within the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation employee training was completed separately from drills and specific to this facility and building. During an interview on August 6, 2024, at 3:25 p.m., LALD/CNS-A, stated the FSEP training provided to employees was not documented separately from fire drills and was general fire safety training and not specific to this building FSEP. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 23 other month as evident by providing documentation evacuation drills were completed only during the day shift and documentation was not available that drills were completed during the evening and night shift. During an interview on August 6, 2024, at 3:25 p.m., LALD/CNS-A, stated documentation was available for fire drills completed during the day shift but was not available for fire drills completed during the evening and night shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, visitors, and staff.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
0 820	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 6, 2024, from 2:15 p.m. to 3:00 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-C, the following distinct hazards were observed: There were 3 separate locking devices on the main front exit door, the door latch lever lock, a dead bolt lock and a privacy lock at the top of the door near the head jamb. Required exit doors in this occupancy are permitted to have 2 separate means of locking. These deficient conditions were visually verified by LALD/CNS-A, and ULP-C, accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
01880	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted to the licensee on May 23, 2019, under the comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan (Waiver) - Addendum to Contract, dated April 4, 2024, indicated R3 received medication administration. R3's Individual Medication Management Plan, dated March 24, 2024, indicated R3 required assistance with medication administration and staff would make sure all R3's medications were secure and locked in the facility medication storage cabinet. On August 7, 2024, at 2:00 p.m., the surveyor asked licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A if R3's prescription Desitin cream was in R3's room or	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
01880	Continued From page 26 stored in the medication cabinet. LALD/CNS-A looked in medication cabinet and ULP-E looked for it in R3's room. When ULP-E opened R3's nightstand drawer to look for the Desitin cream, the surveyor observed one tube of nystatin cream 100,000 units and one tube of triamcinolone acetonide cream 0.5 percent (%) in the top drawer of R3's nightstand. On August 7, 2024, at 4:24 p.m., LALD/CNS-A stated topical medications should not have been stored in R3's room. After the medication was used it should have been returned to the locked medication cabinet. The licensee's Medication Storage policy, dated August 1, 2021, indicated medications would be stored consistent with each residents' medication management plan and service plan. In addition, when medications were managed and stored licensee, medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02350	Continued From page 27 review, the licensee failed to ensure one of two residents (R3) was treated with courtesy, respect, dignity, and privacy when assisted with activities of daily living. 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). R3 was admitted to the licensee on May 23, 2019, under the comprehensive license and began receiving assisted living services on August 1, 2021. R3's diagnoses included Huntington's Disease, anxiety, depression, hypothyroidism, dysphagia, and major neurocognitive disorder. R3's Service Plan (Waiver) - Addendum to Contract, dated April 4, 2024, indicated R3 received medication administration, assistance with bathing, dressing, grooming, continence care, repositioning every two hours, range of motion exercises, housekeeping, laundry, safety checks, and socialization. R3's Assessment, dated August 4, 2024, indicated staff would inform R3 of all cares to be provided. In addition, R3 had a history of behavioral issues that included aggression and that care must be explained to R3 before each task is performed. On August 5, 2024, at 12:46 p.m., the surveyor	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02350	Continued From page 28 observed unlicensed personnel (ULP)-B and ULP-C entered R3's room without knocking on the door. The door from R3's room to the main house hallway was left open during the entire observation. ULP-B and ULP-C each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. R3 was awake and alert with eyes open looking back and forth at the ULPs. ULP-B removed R3's blanket. R3 was wearing a short-sleeved pajama top, incontinence brief, and red slipper socks. ULP-C lowered the head and foot ends of R3's electric bed and raised the entire bed to a higher level. While R3 was lying on her back, ULP-C unfastened the side tapes holding the incontinence brief in place. ULP-B held R3's legs apart at her knees while ULP-C pushed the front of the soiled brief between R3's legs onto the bed. ULP-C used a spray bottle of perineal area cleanser and sprayed the cleanser directly onto R3's exposed skin. ULP-C then used pre-moistened wipes to clean the area and wipe the cleanser away. When R3's front was clean, ULP-B rolled R3 toward them. ULP-C sprayed the perineal cleanser on R3's lower back, buttocks, and upper legs where they had visible bowel movement, then ULP-C used the pre-moistened wipes to clean away the incontinent bowel movement and sprayed cleanser. ULP-C removed the soiled brief from underneath R3 and placed it in the garbage at the foot of the bed. ULP-C then applied barrier cream to R3's buttocks. ULP-B and ULP-C then turned R3 back and forth to get a clean brief pulled up in front and taped at sides and rolled again to get a lift sheet placed under R3. ULP-B removed the soiled under pad from beneath R3. At 12:56 p.m., ULP-B and ULP-C attached the lift sheet to the ceiling lift and raised R3 up off the bed. While R3 was in the air above the bed, the ULPs put new pads on the bed	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02350	Continued From page 29 underneath R3 and smoothed out the bed sheets. They moved R3 up closer to the head of the bed while up in the lift and then lowered the lift to lie R3 down on the bed again. The ULPs worked together to position a pillow behind each of R3's shoulders, one between her knees, a wedge under R3's legs to keep heels elevated off the bed. At 1:02 p.m., ULP-B and ULP-C left R3's room and washed their hands in the kitchen. None of the cares above were explained to R3 prior to or during their occurrence. On August 6, 2024, at 11:19 a.m., the surveyor observed ULP-B and ULP-C in R3's room changing R3's incontinence brief while R3 was in bed. ULP-B and ULP-C were speaking loudly to each other in a language other than English. R3 spoke English. On August 6, 2024, at 11:54 a.m., the surveyor observed ULP-B and ULP-C transfer R3 from bed to reclining wheelchair with ceiling lift. The ULPs did not explain what was happening to R3. The ULPs talked about R3 to the surveyor during the transfer. The ULPs talked about how beautiful R3 looked and stated R3 had a very handsome brother. They stated R3 used to be able to talk but could no longer communicate. ULP-C pointed out a massage chair in R3's room and stated the facility owner had gotten it for staff to use because cares in this house for R2 and R3 were so heavy with so much lifting. ULP-C stated the work was back breaking and the massage chair was nice. On August 7, 2024, at 1:25 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the massage chair was at the facility for staff to use. LALD/CNS-A agreed R3's room was not the best location for a	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02350	Continued From page 30 massage chair that was only used by staff and not used by R3. On August 7, 2024, at 12:19 p.m., the surveyor observed ULP-E and ULP-F enter R3's room without knocking on the door or announcing themselves upon entering the room. ULP-E left the room for less than one minute and upon return did not knock on the door or announce themselves and left R3's room door wide open to the main hallway. ULP-E and ULP-F each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. ULP-F stated to R3, "hi, are you awake?" R3 opened their eyes and looked at ULP-F. The ULPs raised the bed to a good working height, while also lowering the head and foot ends of the bed. Then the ULP's removed R3's blanket and positioning pillows. R3 was wearing a pajama top, incontinence brief, and red slipper socks. The ULPs untaped the sides of the soiled brief and pulled it down in front. ULP-F used peri area cleanser spray and pre-moistened wet wipes to clean R3's peri area. ULP-E crossed R3's left foot over their right foot and the ULP's rolled R3 onto her right side. ULP-F used the spray cleanser and wipes on R3's low back and buttocks, then tucked the soiled brief under R3. ULP-F tucked the clean brief under R3. Then the ULP's rolled R3 back over onto R3's left side. ULP-E removed the soiled brief and used spray cleanser and wipes to clean right side of back and buttocks that ULP-F could not reach from other side. The ULP's rolled R3 onto her back then back over to the right side. ULP-E applied barrier cream to R3's buttocks. The ULPs rolled R3 back onto their back, pulled up middle of brief, and taped the sides. There was also some bowel movement on R3's shirt the ULPs had noticed when changing the brief. ULP-F got a clean shirt out of R3's closet. The	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02350	Continued From page 31 ULPs removed R3's shirt put in laundry basket in room. The ULPs assisted R3's arms into the clean shirt, pulled it over R3's head, then rolled R3 back and forth to pull the back of shirt down so it was smooth and on appropriately. The ULPs moved R3 up in bed using the draw sheet to pull R3 up toward the head of the bed. Then the ULPs fixed the pillow under R3's head to be lower on their neck, placed pillows under R3's right and left shoulders, between their knees, the wedge under their feet, and put the blanket on. ULP-E took the garbage out of the room and returned without knocking on the door or announcing their entrance. The ULPs washed their hands in R3's bathroom and exited the room. On August 7, 2024, at 1:20 p.m., LALD/CNS-A stated they expected all staff to tell the resident what they are doing with each step of cares. On August 7, 2024, at 1:30 p.m., ULP-E stated they should do better about explaining cares to R3. ULP-E stated they follow the same routine for cares every day and fall into their routine of just getting the tasks completed. On August 7, 2024, at 2:25 p.m., via telephone, ULP-C stated they had not thought about explaining the cares to R3 because they had been doing the same cares for so many years. ULP-C stated it was routine and they went through the motions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02410	Continued From page 32	02410		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident's right to privacy 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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02410	Continued From page 33 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: R3 was admitted to the licensee on May 23, 2019, under the comprehensive license and began receiving assisted living services on August 1, 2021. R3's diagnoses included Huntington's Disease, anxiety, depression, hypothyroidism, dysphagia, and major neurocognitive disorder. R3's Service Plan (Waiver) - Addendum to Contract, dated April 4, 2024, indicated R3 received medication administration, assistance with bathing, dressing, grooming, continence care, repositioning every two hours, range of motion exercises, housekeeping, laundry, safety checks, and socialization. R3's Assessment, dated August 4, 2024, indicated staff would knock on R3's door before entering the room. On August 5, 2024, at approximately 11:00 a.m., while providing a tour of the facility to the surveyor, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A entered R3's room without knocking on the door. R3 was awake, with eyes open, looking at LALD/CNS-A and the surveyor. R3 was unable to verbally communicate. On August 5, 2024, at 12:46 p.m., the surveyor observed ULP-B and ULP-C entered R3's room without knocking on the door. The door from R3's room to the hallway was left open during cares of	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02410	Continued From page 34 changing and repositioning. R3's room was at the end of the hallway. The door next to R3's was to a small room that led to the garage. Anyone entering or exiting the house through the garage would be right outside R3's door. The furniture in R3's room was positioned so R3's bed was not visible from outside of the room. During cares, ULP-B and ULP-C each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. R3 was awake and alert with her eyes open looking back and forth at the ULPs. ULP-B removed R3's blanket. R3 was wearing a short-sleeved pajama top, incontinence brief, and red slipper socks. The ULPs changed R3's soiled incontinence brief and repositioned R3 in the bed. Once positioned, the ULPs put the blanket back over R3. During cares R3's legs, peri area, back, and buttocks were exposed without any attempt from the ULPs to cover areas that were not part of care provided at the time. R3's bed was beside a large window that had part of the house deck directly outside of R3's window. The window curtains remained open throughout cares. On August 6, 2024, at 11:19 a.m., the surveyor observed ULP-B and ULP-C in R3's room changing R3's incontinence brief while R3 was in bed with the room door wide open to the hallway. On August 6, 2024, at 11:50 a.m., the surveyor observed ULP-B and ULP-C enter R3's room without knocking on the door and failed to announce themselves upon entering the room. On August 7, 2024, at 12:19 p.m., the surveyor observed ULP-E and ULP-F enter R3's room without knocking on the door or announcing themselves upon entering the room. ULP-E left the room for less than one minute and upon return did not knock on the door or announce	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02410	Continued From page 35 themselves and left R3's room door wide open for the duration of cares. ULP-E closed the curtains to the window. During cares, ULP-E and ULP-F each stood on the sides of R3's electric hospital bed. One ULP on each side of R3's bed. The ULPs removed R3's blanket and positioning pillows. R3 was wearing a pink pajama top, incontinence brief, and red slipper socks. The ULPs untaped the sides of the soiled brief and pulled it down in front. ULP-F used peri area cleanser spray and pre-moistened wet wipes to clean R3's peri area. ULP-F used the spray cleanser and wipes on R3's low back and buttocks, then tucked the soiled brief under R3. ULP-E applied barrier cream to R3's buttocks. The ULPs removed R3's pajama top and assisted R3 to put on a clean top. Then the ULPs moved R3 up in bed using the draw sheet, positioned with pillows, and put the blanket on R3. ULP-E took the garbage out of the room and returned without knocking on the door or announcing their entrance. During cares R3's legs, peri area, back, buttocks, abdomen, and breasts were exposed without any attempt from the ULPs to cover areas that were not part of care provided at the time. On August 7, 2024, at 2:25 p.m., via telephone, ULP-C stated they thought they had gotten in the habit of not knocking on R3's door because they knew R3 was not going to respond but knew they should still knock. On August 7, 2024, at 1:20 p.m., LALD/CNS-A stated they expected all staff to knock on a resident's door and announce themselves upon entering a room. LALD/CNS-A stated they realized they did not knock on R3's door during the facility tour but knew they should have. The licensee's undated Resident's Handbook,	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND CHAMPLIN	6708 119TH PLACE NORTH CHAMPLIN, MN 55316

(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
02410	Continued From page 36 item 5.0, titled Entry by Staff indicated staff will knock or notify the resident when they enter a resident's room. The licensee's Bill of Rights (BOR) policy, dated August 1, 2021, indicated licensee would provide each resident with the Assisted Living Care BOR and all staff would be trained on the concepts/rights contained in the BOR. The licensee's Protecting Resident's Rights policy, dated August 1, 2021, indicated licensee would protect resident's rights and not request or require that any resident waive any of the rights provided at any time for any reason, including as a condition of admission. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/05/24*
Time: 12:00:00
Report: 1039241237

Food and Beverage Establishment Inspection Report

Location:
Golden Pond Champlin
6708 119th Place North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0037525
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637125345
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

STAFF HAVE COMPLETED FOOD SAFETY COURSES. REGISTER WITH MDH TO BECOME CERTIFIED FOOD PROTECTION MANAGERS. GUIDANCE DOCUMENT AND INITIAL CFPM APPLICATION SENT TO ESTABLISHMENT.

Comply By: 08/20/24

Food and Equipment Temperatures

Process/Item: AMBIENT
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: FREEZER ON REFRIG.
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Peggy Anderson.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, wood floor, painted walls with popcorn ceiling and faux-stone countertops with decorative tile backslash. These kitchen finishes and surfaces are clean and well

maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Establishment measures dishwashing machine temperature on a weekly basis using a waterproof irreversible thermometer. Log shows temperature always above 160 degrees F minimum (usually at 170 degrees F).

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen. A supply of disposable food-surface sanitizer wipes is on-hand. An alternative method for sanitize food-contact surfaces, such as countertops, is to use a bleach solution prepared from 1 tablespoon bleach concentrate and 1 gallon of water. Solution should be 50 to 200 ppm Chlorine.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, procedure for thawing raw meats, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241237 of 08/05/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Hilda Look
person-in-charge

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us