Electronically Delivered

April 28, 2025

Licensee
Golden Arms Home Health Care
1488 Jewel Drive
Woodbury, MN 55125

RE: Project Number(s) SL38606016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 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.

MDH 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.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38606	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ARMS HOME HEALTH CARE	1488 JEWEL DRIVE WOODBURY, MN 55125

(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 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: SL38606016-0 On March 31, 2025, through April 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	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.	
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 1 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection between all provided smoke alarms. 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 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).	0 780		

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0 780	Continued From page 2 The findings include: On April 1, 2025, from approximately 1:30 p.m. to 2:47 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B. During the tour, the surveyor observed the following deficient conditions: During the survey, LALD/CNS-B sounded smoke alarms throughout the facility to test interconnection. When smoke alarms were tested the smoke alarm in the dining room did not sound and was not interconnected. When the smoke alarm in the dining room was tested no other alarms sounded. LALD/CNS-B indicated the alarm had been interconnected with the other smoke alarms previously and that they would work to reestablish connection. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 3 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required employee and resident actions. 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:	0 810		

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0 810	Continued From page 4 On April 1, 2025, at approximately 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training. The licensee's FSEP failed to include the following: The FSEP did not include fire procedures for residents. The FSEP should include plans for residents to follow during evacuation. The FSEP should include specific actions in a plan specific to the facility and residents for evacuation during a fire or similar emergency. The FSEP did not include employee actions to be taken in the event of a fire or similar emergency. The FSEP should include specific actions in a plan specific to the facility and residents for evacuation during a fire or similar emergency. During the record review and interview on April 1, 2025, LALD/CNS-B verified the above listed documents were absent from the FSEP. LALD/CNS-B explained fire procedures and indicated that they would create a written document detailing such procedures and stated that they understood requirements and would supplement the existing FSEP with missing information and documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 5 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted September 27, 2024, and had diagnoses including traumatic brain injury. R3 was admitted November 30, 2023, and had diagnoses including major depressive disorder. R4 was admitted December 20, 2024, and had diagnoses including intracranial (within the skull) injury. R2, R3, and R4's signed Residency Agreement dated September 27, 2024, November 30, 2023, and December 20, 2024, respectively, included the following language indicating a waiver of	0 970		

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0 970	Continued From page 6 liability: The licensee's Assisted Living Contract included Miscellaneous Provisions, page 11-12, Section number 1, Insurance Liability and Release "...The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." On March 31, 2025, at 1:09 p.m., owner (O)-A and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated the licensee believed they had corrected the waiver of liability in the assisted living contract after the previous assisted living survey but may have missed updating this waiver section. The surveyor provided education to O-A and LALD/CNS-B on the section of the licensee's assisted living contract containing a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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02310	Continued From page 7	02310		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R2) who utilized hospital style side rails. 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 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 September 27, 2024, and had diagnoses which included traumatic brain injury. R2's signed service plan dated September 27, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, toileting, treatment, and medication management. On March 31, 2025, at 11:50 a.m., the surveyor	02310		

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02310	Continued From page 8 observed R2's bedroom with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B. R2's bedroom included one hospital-style bed with bilateral upper side rails. The side rails were in the upright position. R2's nursing assessment dated January 7, 2025, indicated under the section labeled "Safety" - " Bed rails in use, include description and condition of bed rail: Bed rails for support." The assessment further indicated the bed rails "safety zones" met FDA requirements. R2's medical record lacked: -documentation of measurements of Food and Drug Administration (FDA)-identified zones of entrapment. On April 1, 2025, at 10:22 a.m., LALD/CNS-B stated she had not completed a side rail assessment with measurements of entrapment zones for R2. LALD/CNS-B verbalized she was not aware side rail assessments, including measurements, were required. The surveyor showed LALD/CNS-A the licensee's side rail policy and education was provided. Finally, LALD/CNS-B and O-A stated they planned to ensure R2's side rail was assessed with the required content. The licensee's Side Rail Use policy dated May 31, 2022, included, "1. Before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: a. Level of mobility, including bed mobility b. Level of consciousness c. Level of cognition d. Presence of orthostatic hypotension e. Vision 2. The RN will consider the request of the	02310		

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02310	Continued From page 9 resident, the resident's legal representative and/or the resident's designated representative request for side rails during the evaluation. 3. The RN will discuss with the resident/representative(s) alternatives to the use of side rails. 4. A physical therapy evaluation may be obtained, as appropriate. 5. If the need for side rails is indicated and the resident/resident representative(s) agree to their use, the RN will provide education related to side rails. 6. The RN will document the purpose of the side rails and the education provided. 7. The resident, resident's legal representative or resident's designated representative will co-sign the document agreeing to the benefits and risks of the side rails. 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. 9. Side rails will be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations are not available, the RN will use appropriate nursing judgement related to the implementation of the side rails. 10. The need for side rails will be reassessed and documented as needed, but not less than every 90 days." The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk	02310		

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02310	Continued From page 10 unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."	02310		

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02310	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *04/01/25*
Time: 12:22:56
Report: 1036251067

Food and Beverage Establishment Inspection Report

Location:

Golden Arms Home Health Care
1488 Jewel Drive
Woodbury, MN55125
Washington County, 82

Establishment Info:

ID #: 0042086
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #: 9522376194
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -2 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEDE HINNENDAEL. INSPECTION CONDUCTED IN PRESENCE OF STEFANIE, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD THREE RESIDENTS.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036251067 of 04/01/25.

Certified Food Protection Manager: STEFANIE ASANTE-TOTIMEN

Certification Number: 115373 Expires: 02/22/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
STEFANIE ASANTE-TOTIMEH
PERSON IN CHARGE

Signed: _____
Jeff Johanson