Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 26, 2025

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: May 9, 2025

Dear Administrator:

On May 30, 2025, we notified you a remedy was imposed. On June 24, 2025 the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 9, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 30, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 9, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 9, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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June 26, 2025

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

Re: Reinspection Results
Event ID: 350G12

Dear Administrator:

On June 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 9, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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May 27, 2025

Administrator
Covenant Living of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: May 9, 2025

Dear Administrator:

On May 9, 2025, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
May 27, 2025

Administrator
Covenant Living of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 350G11

Dear Administrator:

The above facility was surveyed on May 2, 2025, through May 9, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/2/25, 5/7/25 and 5/9/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H53223111C (MN00112350) with deficiencies cited at F627. As a result of the investigation, a deficiency was also cited at F842. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate	F 627		6/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/06/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 627	Continued From page 1 because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this	F 627		

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F 627	Continued From page 2 section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 627		

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F 627	Continued From page 3 following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 627		

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F 627	Continued From page 4 rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F 627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 627	Continued From page 5 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 627		

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F 627	Continued From page 6 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to discuss discharge instructions with resident and resident representative upon discharge for 1 of 3 resident (R1). Additionally, the facility failed ensure correct disposition of medications for 2 of 3 residents (R1) when R1 received R2's medications upon discharge. Findings include: R1's face sheet, undated, indicated admission date to the facility of 12/23/24. R1's diagnoses included atrioventricular block and unspecified diastolic (congestive) heart failure. R1's Minimum Data Set (MDS) dated 2/3/25, identified intact cognition and no verbal behaviors during the assessment period. R2's face sheet, undated, indicated admission date to the facility of 1/6/25. R1's February 2025 Medication Administration Record (MAR) did not indicate administration for sulfamethoxazole or lisinopril. R2's February 2025 MAR indicated administration for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by mouth two times daily. Facility form titled Discharge Sending Medications Homes dated 2/3/25, indicated sulfamethoxazole 800 milligrams one tablet oral two times daily was listed on R1's form. Lisinopril	F 627	Covenant Living of Golden Valley Care and Rehabilitation Center respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F TAG 627 S/S = d Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) According to the statement of deficiencies (2567) based on interview and document review, the facility failed to discuss discharge instructions with resident and resident representative upon discharge for 1 of 3 resident (R1). Additionally, the facility failed ensure correct disposition of medications for 2 of 3 residents (R1) when R1 received R2's medications upon discharge. " How corrective action(s) will be accomplished for those residents found to	

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	245322	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 7 pharmacy sticker was not visible on form. Discharge Sending Medication Home indicated, "I certify the medication listed (pharmacy card stickers) above are released to me, with R1's signature and dated 2/3/25. The form failed to have evidence of a witness/nurse signature. During interview on 5/7/25 at 1:21 p.m., assistant director of nursing (ADON) stated their discharge process included a review of medications with the resident and to answer any questions. ADON was not aware of any medications sent home with the wrong resident and if this were to occur, management should have been notified. During interview on 5/7/25 at 2:42 p.m., registered nurse (RN)-A stated he worked on the transition care unit at the facility and completed discharge process with the residents. RN-A stated he did not recall completing R1's discharge. RN-A denied sending R2's medication, sulfamethoxazole home with R1, discovering the error later, and then ordering more sulfamethoxazole for R2 later. RN-A stated if an error like that occurred, he would contact his supervisor. During interview on 5/7/25 at 3:49 p.m., pharmacist (Pharm) stated on 2/5/25 there was a request by the facility to fill R2's sulfamethoxazole and the facility would be responsible to pay for the additional medications. Pharm stated the facility reported to have used their emergency kit supply of sulfamethoxazole until requesting more on 2/5/25. Lisinopril was not reordered but no doses were verified to be omitted for R2. During interview on 5/7/25 at 4:02 p.m., director of nursing (DON) stated they were not aware of	F 627	have been affected by the deficient practice; Corrective actions which will be accomplished for those residents found to be affected by the alleged deficient practice: R1 Discharged from the facility on 2/3/2025. R2 Discharged from the facility on 2/23/2025. " How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of discharged residents from the facility from 5/9 to 6/2 was completed with no findings found. " What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Measures the facility will take or systems the facility will alter to ensure that the alleged problem will be correct and not recur: Nursing staff RN/LPN educated on the existing procedure to follow for discharging residents. " How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is	

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F 627	Continued From page 8 the medication errors until this survey. DON indicated he believed RN-A knew of the error as was the one who ordered more medications for R2, and had not received authorization before ordering. DON stated upon discharge the nurse was to review the discharge paperwork, including the medications that were being sent home with the resident (and/or resident representative). He indicated this was likely not done as the medication disposition error would have been caught at that time if the process was followed. DON added, during their investigation, when reviewing R1's discharge records, the medication sticker for R2's sulfamethoxazole was included in R1's record, solidifying the error. Review of R1's discharge paperwork lacked evidence RN-A discussed discharge paperwork and medications with R1 and family. Additionally, no RN signature was found on the Recapitulation of Stay records. During interview on 5/9/25 at 2:47 p.m., R1's family member (FM) stated no discharge paperwork or medications were reviewed at the time of discharge. Upon R1 returning home it was discovered another resident's medications (sulfamethoxazole and lisinopril) were sent home with her. FM recalled R1's medications were handed over from RN-A to the family in a bag. FM indicated a serious concern related to this error as, if his mother would have taken these medications, it could have caused her significant harm. Facility policy titled "Adverse Consequences and Medication Errors," revised date 2/2023, indicated a procedure was to review the resident's medication regimen for efficacy and actual or	F 627	achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system. The director of nursing (DON) or designee will audit all discharges for four weeks for compliance of the procedure for discharging residents. This audit then will reduce to three discharges a week for three months. Findings will be reported at QAPI for three months. " Correct action date. 6/6/2025	

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F 627	Continued From page 9 potential medication -related problems on an ongoing basis. Monitor the resident for medication-related adverse consequences when there is a medication error (wrong or expired medication). In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare. Promptly notify the provider of any significant error. Facility polity titled "Transfer or Discharge, Resident-Initiated", dated 10/2022, indicated medical record would contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, discharge care plan and document discussions with the resident or representative, containing details of discharge planning and arrangements for post-discharge care.	F 627		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		6/6/25

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F 842	Continued From page 10 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F 842		

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F 842	Continued From page 11 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain confidential clinical records for 2 of 3 residents (R1 and R2) when two of R2's Pharmacy Cards were sent with R1 who was discharging home. Findings include: R1's Minimum Data Set (MDS) dated 2/3/25, identified intact cognition. R1's February 2025 Medication Administration Record (MAR) did not indicate an order for sulfamethoxazole or lisinopril. R2's MDS dated 2/23/25, identified intact cognition. R2's February 2025 MAR indicated an order for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by moth two times daily. R2's pharmacy card identified protected information such as his first name, middle initial, last name, his doctor's name and information, the	F 842	F TAG 842 S/S = d Resident Records Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) According to the statement of deficiencies (2567) based on interview and record review, the facility failed to maintain confidential clinical records for 2 of 3 residents (R1 and R2) when two of R2's Pharmacy Cards were sent with R1 who was discharging home. " How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Corrective actions which will be accomplished for those residents found to be affected by the alleged deficient practice: R1 Discharged from the facility on 2/3/2025. R2	

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F 842	Continued From page 12 medication and prescribed route/dosage and what the medications were prescribed for (high blood pressure, antibiotic for infection). R2 is protected by the Health Insurance Portability and Accountability Act (HIPPA) which includes protected health information includes medical history, test information, and any personally identifiable information. The 18 HIPPA identifiers include patient names, geographical elements, dates related to health or identity, telephone numbers, social security numbers and more. During interview on 5/7/25 at 1:21 p.m., assistant director of nursing (ADON) stated upon discharge the nurse was to review medications with the discharging resident and or representative; ADON was not aware wrong medications was discharged with the wrong resident. During interview on 5/7/25 at 2:42 p.m., registered nurse (RN) denied sending R1 home with R2's medication. During interview on 5/7/25 at 4:02 p.m., director of nursing (DON) stated they were not aware a resident was discharged with another resident's medications but was able to verify R2's medication sulfamethoxazole pharmacy card sticker was in R1's discharge record. During interview on 5/9/25 at 2:47 p.m., R1's family member verified and provided pictures of R2's medication sulfamethoxazole and lisinopril which was sent home with R1 upon discharge.	F 842	Discharged from the facility on 2/23/2025. " How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of discharged residents from the facility from 5/9 to 6/2 was completed with no findings found. " What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Measures the facility will take or systems the facility will alter to ensure that the alleged problem will be correct and not recur: Nursing staff RN/LPN educated on the procedure to follow for discharging residents and HIPAA compliance. " How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system. The director of nursing (DON) or designee will audit all discharges for four weeks for compliance of the procedure for discharging residents. This audit then will reduce to three discharges a week for three months. Findings will be reported at	

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F 842	Continued From page 13	F 842	QAPI for three months. " Correct action date. 6/6/2025	

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	00183	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/2/25, 5/7/25 and 5/9/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H53223111C (MN00112350) with a licensing order issued at 0690. As a result of the investigation, a licensing order was also issued at 0625. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the	2 625		6/6/25

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2 625	Continued From page 3 three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to maintain confidential clinical records for 2 of 3 residents (R1 and R2) when two of R2's Pharmacy Cards were sent with R1 who was discharging home. Findings include: R1's Minimum Data Set (MDS) dated 2/3/25, identified intact cognition. R1's February 2025 Medication Administration Record (MAR) did not indicate an order for sulfamethoxazole or lisinopril. R2's MDS dated 2/23/25, identified intact cognition.	2 625	Corrected	

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2 625	Continued From page 4 R2's February 2025 MAR indicated an order for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by moth two times daily. R2's pharmacy card identified protected information such as his first name, middle initial, last name, his doctor's name and information, the medication and prescribed route/dosage and what the medications were prescribed for (high blood pressure, antibiotic for infection). R2 is protected by the Health Insurance Portability and Accountability Act (HIPPA) which includes protected health information includes medical history, test information, and any personally identifiable information. The 18 HIPPA identifiers include patient names, geographical elements, dates related to health or identity, telephone numbers, social security numbers and more. During interview on 5/7/25 at 1:21 p.m., assistant director of nursing (ADON) stated upon discharge the nurse was to review medications with the discharging resident and or representative; ADON was not aware wrong medications was discharged with the wrong resident. During interview on 5/7/25 at 2:42 p.m., registered nurse (RN) denied sending R1 home with R2's medication. During interview on 5/7/25 at 4:02 p.m., director of nursing (DON) stated they were not aware a resident was discharged with another resident's medications but was able to verify R2's medication sulfamethoxazole pharmacy card sticker was in R1's discharge record.	2 625		

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	00183	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 5 During interview on 5/9/25 at 2:47 p.m., R1's family member verified and provided pictures of R2's medication sulfamethoxazole and lisinopril which was sent home with R1 upon discharge. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for discharge procedures and resident record protects. The director of nursing or designee could develop a system to educate staff about disposition of medication upon discharge, and audit for competency. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 625		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 690	Corrected	6/6/25

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2 690	Continued From page 6 facility failed to discuss discharge instructions with resident and resident representative upon discharge for 1 of 3 resident (R1). Additionally, the facility failed ensure correct disposition of medications for 2 of 3 residents (R1) when R1 received R2's medications upon discharge. Findings include: R1's face sheet, undated, indicated admission date to the facility of 12/23/24. R1's diagnoses included atrioventricular block and unspecified diastolic (congestive) heart failure. R1's Minimum Data Set (MDS) dated 2/3/25, identified intact cognition and no verbal behaviors during the assessment period. R2's face sheet, undated, indicated admission date to the facility of 1/6/25. R1's February 2025 Medication Administration Record (MAR) did not indicate administration for sulfamethoxazole or lisinopril. R2's February 2025 MAR indicated administration for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by mouth two times daily. Facility form titled Discharge Sending Medications Homes dated 2/3/25, indicated sulfamethoxazole 800 milligrams one tablet oral two times daily was listed on R1's form. Lisinopril pharmacy sticker was not visible on form. Discharge Sending Medication Home indicated, "I certify the medication listed (pharmacy card stickers) above are released to me, with R1's signature and dated 2/3/25. The form failed to have evidence of a witness/nurse signature.	2 690		

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2 690	Continued From page 7 During interview on 5/7/25 at 1:21 p.m., assistant director of nursing (ADON) stated their discharge process included a review of medications with the resident and to answer any questions. ADON was not aware of any medications sent home with the wrong resident and if this were to occur, management should have been notified. During interview on 5/7/25 at 2:42 p.m., registered nurse (RN)-A stated he worked on the transition care unit at the facility and completed discharge process with the residents. RN-A stated he did not recall completing R1's discharge. RN-A denied sending R2's medication, sulfamethoxazole home with R1, discovering the error later, and then ordering more sulfamethoxazole for R2 later. RN-A stated if an error like that occurred, he would contact his supervisor. During interview on 5/7/25 at 3:49 p.m., pharmacist (Pharm) stated on 2/5/25 there was a request by the facility to fill R2's sulfamethoxazole and the facility would be responsible to pay for the additional medications. Pharm stated the facility reported to have used their emergency kit supply of sulfamethoxazole until requesting more on 2/5/25. Lisinopril was not reordered but no doses were verified to be omitted for R2. During interview on 5/7/25 at 4:02 p.m., director of nursing (DON) stated they were not aware of the medication errors until this survey. DON indicated he believed RN-A knew of the error as was the one who ordered more medications for R2, and had not received authorization before ordering. DON stated upon discharge the nurse was to review the discharge paperwork, including the medications that were being sent home with	2 690		

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2 690	Continued From page 8 the resident (and/or resident representative). He indicated this was likely not done as the medication disposition error would have been caught at that time if the process was followed. DON added, during their investigation, when reviewing R1's discharge records, the medication sticker for R2's sulfamethoxazole was included in R1's record, solidifying the error. Review of R1's discharge paperwork lacked evidence RN-A discussed discharge paperwork and medications with R1 and family. Additionally, no RN signature was found on the Recapitulation of Stay records. During interview on 5/9/25 at 2:47 p.m., R1's family member (FM) stated no discharge paperwork or medications were reviewed at the time of discharge. Upon R1 returning home it was discovered another resident's medications (sulfamethoxazole and lisinopril) were sent home with her. FM recalled R1's medications were handed over from RN-A to the family in a bag. FM indicated a serious concern related to this error as, if his mother would have taken these medications, it could have caused her significant harm. Facility policy titled "Adverse Consequences and Medication Errors," revised date 2/2023, indicated a procedure was to review the resident's medication regimen for efficacy and actual or potential medication -related problems on an ongoing basis. Monitor the resident for medication-related adverse consequences when there is a medication error (wrong or expired medication). In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare.	2 690		

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2 690	Continued From page 9 Promptly notify the provider of any significant error. Facility polity titled "Transfer or Discharge, Resident-Initiated", dated 10/2022, indicated medical record would contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, discharge care plan and document discussions with the resident or representative, containing details of discharge planning and arrangements for post-discharge care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for discharge planning and procedures. The director of nursing or designee could develop a system to educate staff about disposition of medication upon discharge, discharge summary and review with resident and/or representative and audit for competency. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 690		