STATE LICENSING COMPLIANCE REPORT

Report #: HL346005382C

Date Concluded: April 2, 2024

Name, Address, and County of Facility Investigated:
Golden Touch Health Care LLC
6800 Scott Ave North
Brooklyn Center, MN 55429

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, RN, Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34600	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	6800 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL346005382C On March 7, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #Hl346005382C, tag identification 0730, 0970, 1650, and 2400.	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.	
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for four of four residents (R1, R5, R6, and R7) discharged from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the facility on March 10, 2023, and discharged on August 31, 2023. R1's discharge summary, signed by a nurse on October 31, 2023, indicated the resident was discharged to another assisted living facility. R5 R5 was admitted to the facility on October 28, 2022, and discharged on June 9, 2023. R5's discharge summary, signed by a nurse on	0 730		

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0 730	Continued From page 3 June 9, 2023, indicated the resident was discharged to a treatment center. R7 R7 was admitted to the facility on October 27, 2023, and discharged on December 7, 2023. R7's discharge summary, signed by RN-B on December 7, 2023, indicated the resident was discharged to another unit within the same facility. R1, R5, and R7's discharge summary lacked the following required content: - course of illnesses; - allergies; - treatments and therapies; - pertinent lab, radiology, consultation results; - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status; - a reconciliation of all pre-discharge medications and post-discharge prescribed, including over-the-counter medications; and - a post-discharge plan which indicates where the resident plans to reside, any arrangements that have been made for follow-up care, any medical and nonmedical services resident will need. R6 R6 was admitted to the facility on June 26, 2023, and discharged on October 10, 2023. R6's discharge summary was requested from the licensee. An email from RN-B on March 25, 2024, at 12:35 p.m., indicated she could not find any discharge paperwork for R6. An email from PM-A on March 25, 2024, at 1:11 p.m., indicated R6 discharged to another house on October 10, 2023.	0 730		

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0 730	Continued From page 4 On March 26, 2024, at 11:56 a.m., the registered nurse (RN)-B stated she knew the basics requirements for a discharge summary, but things keep changing so she was not exactly sure of everything. A discharge summary policy was requested from the licensee. The Licensed Assisted Living Director (LALD)-C indicated in an email on March 25, 2024, at 6:14 p.m., the licensee did not have a policy related to discharge summary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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	0 970		

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0 970	Continued From page 5 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 the potential to affect a large portion or all the residents). The findings include: The licensee's Resident Contract for Assisted Living, Resident Agreement, dated May 3, 2021, on page 16, section 27, indicated "Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health- related, supportive, or other services from third party providers. Landlord may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Room or on Landlord's premises." On March 26, 2024, at 2:51 p.m., Licensed Assisted Living Director (LALD)-C stated he was not aware of this legal language and will have it removed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01650	Continued From page 6	01650		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R2 and R4). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 7	01650		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

The licensee undated Home Care Service Plan included a table with seven columns and five rows. The columns were labeled as follows: service description; frequency; staff title; schedule; fees/financial responsibility; payer source; and title of supervisor. The rows were labeled as follows: services/care plan; personal care service room and board as in rental agreement as per care plan; medication management, vital sign monitoring (BP, T.R.P), enteral feeding and management, tracheotomy care and management; client review/reassessment; and supervisory visits for unlicensed staff.

R2
R2's diagnoses included diabetes, schizophrenia, mild intellectual disability, depressive disorder, and anxiety.

R2's 90-day assessment, dated January 13, 2024, indicated R2 had anger outburst, paranoia, property destruction, and verbal and physical aggression. Other areas of the assessment indicate no change from prior assessment. R2's Client Evaluation, dated October 17, 2023, indicated R2 was alert and oriented, was independent with dressing, grooming, and

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01650	Continued From page 8	01650		

walking. The Client Evaluation further indicated R2 had fluctuating blood sugars, insulin management, verbal, and physical aggression, and was resistive to redirection.

R2's Home Care Service Plan, dated July 13, 2022, had a check mark in the services/care plan description row, with a check mark indicating the frequency was on admission, within 5 days, annually, and as needed. The same column had a check mark and a dollar amount by the "room/board rate" under the "fees/financial responsibility" column. The only other thing checked on the table was the frequency column in the "client review/reassessment" row, which was on admission, within 14 days, every 90 days, and as needed.

R4
R4's diagnoses included quadriplegia (paralysis of all four limbs), myasthenia (chronic autoimmune disorder in which antibodies destroy the communication between nerves and muscle, resulting in weakness of the skeletal muscles), major depressive disorder, opioid dependence.

R4's Home Care Service Plan, dated October 5, 2023, had a check mark in the services/care plan description row, with a check mark indicating the frequency was on admission, within 5 days, annually, and as needed. The same column had a check mark and a dollar amount by the "room/board rate" under the "fees/financial responsibility" column. The only other thing checked on the table was the frequency column in the "client review/reassessment" row, which was on admission, within 14 days, every 90 days, and as needed.

R2 and R4's service plan lacked the following

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01650	Continued From page 9 required content: - a description of the services to be provided; - the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; and - the methods of monitoring assessments of the resident; On March 26, 2024, at 11:56 a.m., the registered nurse (RN)-B stated she knew the basics requirements for a service plan, but things keep changing so she was not exactly sure of everything. The Service Plan policy, dated August 1, 2021, indicated it was for a different licensee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
02400 SS=D	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their	02400		

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02400	Continued From page 10 discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R2) was allowed to have an overnight visitor. 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: R2's diagnoses included diabetes, schizophrenia, mild intellectual disability, depressive disorder, and anxiety. During an observation on Thursday, March 7, 2024. At 3:50 p.m., as the investigator entered the facility and was standing in the doorway introducing herself, unlicensed personnel (ULP)-D was standing near the entrance and R2 was standing a few steps back to ULP-D's right. As the investigator was explaining the reason for her visit, R2 lunged forward, pushing ULP-D and the investigator out of the way and ran out the door. ULP-D was yelling "don't let him out." ULP-E entered the room from around a corner and went out the door to watch R2. R2 walked across the road and sat down on the curb. A brief time passed before a police car pulled up and an	02400		

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02400	Continued From page 11 officer got out of the car and started talking to R2. During an observation on Thursday, March 7, 2024. at 4:05 p.m., the law enforcement officer entered the home and discussed the incident with ULP-D and ULP-E. The officer told ULP-D and ULP-E that R2 seemed to be calmed down and wanted to know what the plan was for R2. ULP-D said R2's guardian wanted him to go to the emergency room and be placed on a hold for evaluation, and the ambulance had already been called. The officer said R2 seemed to be upset because staff would not allow his brother to stay overnight at the facility, at which time ULP-D responded that R2's brother was not allowed to stay overnight. After further discussion, the ambulance arrived, a call to R2's guardian was made, and R2 was taken to the emergency room by the ambulance. An incident report dated March 7, 2024, at 3:00 p.m., indicated R2 got mad at staff when they told him his brother could not stay overnight. The incident report indicated R2 started yelling, cussing, getting in staffs face, spitting on staff, and followed staff to her car. The report indicated staff notified management, called the police, and the ambulance to take R2 to the emergency room. During an interview on Thursday, March 7, 2024. at 4:15 p.m., R2 stated his brother had spent the night one other time and he did not understand why he could not stay again. R2 stated the nurse told him his brother could spend the night, but other staff told him his brother could not spend the night. R2 stated the other staff did not give him a reason his brother could not spend the night.	02400		

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02400	Continued From page 12 During an interview on Thursday, March 7, 2024. at 4:25 p.m., ULP-D stated R2's brother is not allowed to stay overnight. ULP-D stated she was not sure why R2's brother could not stay overnight. During an interview on Thursday, March 7, 2024. At 4:50 p.m., program manager (PM)-A stated R2's brother is allowed to visit, and he did stay overnight one time. when asked why R2's brother staying overnight was a problem now and if visits were addressed in the assisted living contract, PM-A called someone to ask and never responded to my questions. During an interview on Thursday, March 19, 2024. At 12:25 p.m., Licensed Assisted Living Director (LALD)-C stated residents are allowed to have visitors whenever they want but we do not let visitor come in the middle of the night for safety reasons. LALD-C stated R2 is allowed to have his brother stay overnight and was not sure who told him his brother could not. The facilities Resident Contract for Assisted Living dated May 3, 2021, section number 14 - Occupancy and Use of The Room, letter C - Visitors, indicated residents were free to receive visitors at times of their choosing. The section indicated the facility did not have restricted visiting hours. TIME PERIOD FOR CORRECTION: Seven (7) days	02400		