DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 25, 2022

Administrator
Golden Horizons Of Worthington
1790 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL30345015

Dear Administrator:

On July 8, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the April 1, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

May 20, 2022

Administrator
Golden Horizons Of Worthington
1790 Collegeway
Worthington, MN 56187

RE: Project Number(s) SL30345015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on April 1, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

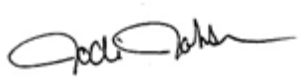
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS OF WORTHINGTON	1790 COLLEGEWAY WORTHINGTON, MN 56187

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 30345015 On, March 28, 2022, through April 1, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 33 residents, all of whom recieved services under the provider's Assisted Living with Dementia Care license. On March 30, 2022, at 9:22 a.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of G (level three, isolated).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems 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: During the entrance conference on March 28, 2022, at approximately 9:35 a.m. licensed assisted living director/registered nurse	0 250		

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0 250	Continued From page 3 (LALD/RN)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 19, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified,	0 250		

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0 250	Continued From page 6 managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (10) medication and treatment management; and (11) delegation of tasks by registered nurses or licensed health professionals As a result of this survey, the following orders were issued 0510, 0550, 1460, 1610, 1620, 1750, 1760, 1880, 1890, 1900, 1910, 2240, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services	0 430		

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0 430	Continued From page 7 allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of two residents (R1 and R2) with records reviewed. 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: On March 28, 2022, at approximately 9:35 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated all 33 residents residing at the facility received services under the assisted living licensure. R1 and R2's record lacked a uniform checklist	0 430		

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0 430	Continued From page 8 disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R1 began receiving services under the assisted living licensure on August 1, 2021. R1's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, indicated services provided included dressing and grooming assist, medication management, blood glucose monitoring, bathing, toileting and transferring assistance. R1's "2022 Documents Update" signed January 4, 2022, included the UDALSA as a document received by R1. However, R1's record lacked evidence she had received the UDALSA on August 1, 2021, when services began under the assisted living licensure. R1's "[The licensee] Lease Addendum for Assisted Living License 2021" signed September 8, 2021, lacked evidence the UDALSA had been provided to R1. On March 28, 2022, at 12:06 p.m. unlicensed personnel (ULP)-B was observed administering oral medications, checking blood glucose, and administering insulin. R2	0 430		

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0 430	Continued From page 9 R2 began receiving services under the assisted living licensure on August 1, 2021. R2's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, identified services provided included medication management, blood glucose monitoring, bathing, and Ted hose assistance. This identified she received the UDALSA at that time. However, R2's record lacked evidence she had received the UDALSA on August 1, 2021 when services first began. R2's "[The licensee] Lease Addendum for Assisted Living License 2021" dated October 1, 2021, lacked evidence the UDALSA had been provided to R2. On March 30, 2022, at approximately 12:00 p.m. ULP-C was observed administering medications to R2. On March 30, 2022, at 11:30 a.m. LALD/RN-A stated a new contract had not been signed by residents previously served under the comprehensive license. Instead the "[The licensee] Lease Addendum for Assisted Living License 2021" document had been provided and signed by the residents. LALD/RN-A confirmed this did not include the UDALSA for any of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 10 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 33 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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	30345	A. BUILDING: _____ B. WING _____	04/01/2022

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0 480	Continued From page 11 and Beverage Establishment Inspection Report dated March 31, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all 33 residents.	0 485		

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0 485	Continued From page 12 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 the potential to affect a large portion or all the residents). The findings include: On March 28, 2022, at approximately 11:10 a.m. during the facility tour with licensed assisted living director/registered nurse (LALD/RN)-A, a menu was not observed to be available for the residents. This was confirmed by LALD/RN-A and an unidentified kitchen staff. LALD/RN-A stated it should be posted. On March 30, 2022, at approximately 1:30 p.m. R1 stated there were no menus posted. This frustrated her as she wouldn't know if it was something she did not like ahead of time so she could make alternative plans. The licensee's Dietary Services policy dated September 1, 2020, identified "The [facilities] menus are prepared a week in advance and made available to residents at that time." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 13 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During continuous observation on March 28, 2022, at 12:06 p.m. unlicensed personnel (ULP)-B administered oral medications to R1 and asked her to go to her room so she could check	0 510		

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0 510	Continued From page 14 her blood sugar. ULP-B went to R1's room and placed gloves, opened medication drawer and noted there were no blood glucose test strips in the drawer. She then removed her gloves and went to check with the nurse. ULP-B returned to the room carrying a single test strip, stating she found one. She put on gloves, completed blood glucose testing, and then removed the gloves. She then used her phone to notify the RN of blood glucose results. The RN instructed her on the correct insulin dose to administer. ULP-B retrieved insulin from the refrigerator and put on gloves. She administered the medication and removed the gloves. Without washing her hands, ULP-B went to another resident's room to answer a call light. At 12:25 p.m., ULP-B returned to medication cart, set up medications for R6 and administered them. At 12:28 p.m., ULP-B set up oral medications for R7, put on gloves, and brought the medication to his room. She placed his medication on the counter per his request, opened the locked medication drawer, took out a nebulizer and set up the nebulizer for him. She left the room and removed gloves. ULP-B failed to wash hands or use hand sanitizer throughout the observation. At 1:12 p.m., ULP-B stated she sanitized her hands "every so often throughout the day." Stated she had washed her hands "a little while ago" and she also did use the sanitizer on dispensers in the hallway. During continuous observation on March 29, 2022, at 7:59 a.m. ULP-B was setting up medications for R3, when R3 complained of pain from his urinary catheter. ULP-B brought R3 into the bathroom and administered the medications. She then applied gloves, lowered R3's pants and checked urinary catheter, checked insertion site, urinary flow through tubing, the strap securing the catheter and adjusted it, and then assisted to pull	0 510		

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0 510	Continued From page 15	0 510		

up pants. ULP-B removed gloves, and failed to wash hands or use hand sanitizer. She walked with R3 down the hallway opening curtains and window shades. ULP-B then assisted him to his room and helped R3 to lay down in bed. ULP-B used her phone to call the RN and notify her of R3's pain. ULP-B returned to the medication cart and retrieved R3's eye drops and placed them in her pocket. She then placed gloves and returned to R3's room. She administered his eye drops, returned to cart, removed gloves and documented. She then began to set up medications for R13. ULP-B put on gloves, carried eye drops and went to R13's room, but R13 was in the bathroom. ULP-B placed the eye drops in her pocket and returned to R3's room to check on him. ULP-B returned to the medication cart, changed gloves and returned to R13's room. R13 was still in the bathroom. ULP-B returned to the medication cart and put the eye drops away. R14 walked out of her room with her top unbuttoned. ULP-B assisted R14, and then removed R14's medications from the medication cart and sanitized hands.

On March 29, 2022, at 8:25 a.m. ULP-D stated she used hand sanitizer between administering medications to residents and she would wash hands after doing treatments, wound care, insulin, or blood glucose monitoring.

On March 29, 2022, at approximately 8:30 a.m. ULP-D set up oral medication for R9. ULP-D applied gloves and brought the medications to R9's room. ULP-D placed oral medications on a counter and opened the locked medication drawer. ULP-D removed nasal spray, a wipe for washing eyelids, and eye drops. ULP-D handed R9 the nasal spray for self administration, assisted her to wipe her eyes, and administered

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0 510	Continued From page 16 the eye drops. She returned the medications to the medication drawer and instructed R9 to take her medications. She then exited the room without removing her gloves, and went to R4's room to answer a call light. ULP-D assisted R4 to the bathroom and onto the toilet. ULP-D then removed her gloves and washed her hands. On March 30, 2022, at 11:30 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated staff were expected to perform hand hygiene between every medication pass and between providing cares on each person. The licensee's Infection Control policy dated March 18, 2020, identified "[The licensee] will establish and maintain an effective infection control policy that complies with accepted healthcare, medical and nursing standards guided by the Department of Health for infection control. [The licensee] provides a safe and clean environment through monitoring and management of facility infection control programs." The licensee's Gloves policy dated March 18, 2020, identified "Gloves are to worn whenever there may be direct contact between any employee and contaminated objects." The procedure included the following steps: "1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. Dispose of in proper receptacle.	0 510		

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0 510	Continued From page 17 6. Rewash hands." The licensee's Hand Washing policy dated March 18, 2020, identified "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: - Before, during, and after preparing food - Before eating food - Before and after caring for someone who is sick - Before and after treating a cut or wound - After using the restroom - After changing incontinent products or cleaning up after someone who has used the toilet - After blowing your nose, coughing, or sneezing - After touching an animal or animal waste - After handling pet food or pet treats - After touching garbage" "Alcohol-Based Hand Sanitizers (ABHS} - ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands." The licensee's Standard Precautions policy dated March 18, 2020, identified "Hands should be washed after removing gloves and after any direct contact with body secretions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 18 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post, in a conspicuous place, the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems 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: The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the	0 550		

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0 550	Continued From page 19 individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). During a facility tour on March 28, 2022, at approximately 11:10 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A, the common areas shared by residents, staff, and visitors, a complaint form was observed on a clipboard in an activity room; however, it lacked the required posting of the grievance procedure and contact information for the Ombudsman. LALD/RN-A confirmed the required posting was not present in the common areas. The licensee's Grievance Policy dated August 1, 2021, identified "[the licensee] will promptly and appropriately respond to all grievances from residents, resident representatives, family members, and staff regarding services provided to the resident and other situations related to the organization. Residents and staff shall be made aware of grievance procedures." "Each resident or resident representative will receive a written notice of [the licensee] process for receiving and resolving complaints that includes: a. Resident right to complain to our facility about the services received by our staff. b. The method of submitting a complaint c. A description of [the licensee] complaint resolution process available to residents d. The name and contact information of the person representing the facility designated to handle and resolve complaints.	0 550		

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0 550	Continued From page 20 e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. f. A Statement that [the licensee] will not take any action that negatively affects a resident in retaliation for a complaint made or a concern expressed by the resident or the resident representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for	0 640		

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0 640	Continued From page 21 reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on March 28, 2022, at approximately 11:10 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A, the common areas shared by residents, staff, and visitors, lacked posted information and phone numbers for reporting to MAARC and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. LALD/RN-A confirmed the required posting was not present in the common areas. The licensee's "Vulnerable Adult Reporting" policy dated March 18, 2020, identified "[The licensee] is committed to providing a safe and secure environment for its clients free of neglect and abuse by following current regulations and guidance from the Minnesota Department of Health." The policy failed to identify posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center and	0 640		

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0 640	Continued From page 22 failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with	0 650		

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0 650	Continued From page 23 the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (licensed assisted living director/registered nurse (LALD/RN)-A and unlicensed personnel (ULP)-B and ULP-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD/RN-A, ULP-B, and ULP-C lacked documentation of a completed background study in their employee files. LALD/RN-A LALD/RN-A started providing services under the comprehensive home care license on February 15, 2016, and under the assisted living with dementia care license beginning August 1, 2021. LALD/RN-A's background study clearance was dated July 20, 2021. ULP-B ULP-B started providing services under the	0 650		

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0 650	Continued From page 24 comprehensive home care license on May 14, 2021, and under the assisted living with dementia care license beginning August 1, 2021. ULP-B's background study clearance was dated March 13, 2022. ULP-C ULP-C started providing services under the comprehensive home care license on July 7, 2021, and under the assisted living with dementia care license beginning August 1, 2021. ULP-C's background study clearance was dated February 11, 2022. On March, 31, 2022 at 11:32 a.m. LALD/RN-A stated background studies had been completed upon hire; however, they did not maintain copies in the employee's files. The licensee's Employee Records policy dated March 18, 2020, identified the employee records must include "documentation of the background study as required under section 144.057. Background studies are initiated upon hire and clearance will be verified prior to independently working." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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	30345	A. BUILDING: _____ B. WING _____	04/01/2022

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0 660	Continued From page 25 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees, (unlicensed personnel (ULP)-B) with records reviewed. 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:	0 660		

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0 660	Continued From page 26 ULP-B started providing services under the comprehensive home care license on May 14, 2021, and under the assisted living with dementia care license beginning August 1, 2021. ULP-B's tuberculosis screening was completed on August 27, 2021. The first step TST was administered on August 27, 2021, and read as negative on August 29, 2021. The second step TST was administered on September 8, 2021, and read as negative on September 10, 2021. ULP-B's screening and first step of TST testing failed to be completed prior to providing direct cares. On March 31, 2022, at approximately 10:00 a.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed the TB screening and first step TST was not completed prior to providing direct cares to residents. The licensee's Tuberculosis and Staff Screening policy dated March 18, 2020, identified "Staff of [licensee name] shall be screened and tested for tuberculosis prior to the staff being exposed to clients. Screening frequency shall be conducted based on the results of the Community TB Risk Assessments." "Screening shall be conducted as follows: 1. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool. 2. New staff shall have a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool. 3. No staff shall be permitted to begin work where the work involves sharing the air space with home care clients until the negative results of the first Mantoux are read and documented."	0 660		

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0 660	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and have	0 680		

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0 680	Continued From page 28 available a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on March 28, 2022, at approximately 11:10 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A, of the common areas shared by residents, staff, and visitors, there was no observed evidence the facility's emergency plan was posted or available to visitors and residents. LALD/RN-A confirmed the required posting was not present in the common areas. The licensee's Emergency Preparedness Manual Planning, Policy and Procedures binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The facility's plan lacked the following required content: -an assessment of the at risk population's needs; -policies and procedures that are stored in a central place; -procedure for tracking staff and residents; -development of all policies and procedures,	0 680		

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0 680	Continued From page 29 based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; and -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On April 1, 2022, at 9:56 a.m. LALD/RN-A stated emergency preparedness policies had not been reviewed since COVID-19 started in March of 2020. The emergency preparedness plan had not been posted. After review of Appendix Z, LALD/RN-A verified the general policies failed to meet the requirements. The licensee's Disaster Planning and Emergency Preparedness Plan dated March 18, 2020, did not identify any annual reviews or updates to the plan. No additional information was provided.	0 680		

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0 680	Continued From page 30 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 28, 2022, at approximately 1:30 p.m. with Maintenance	0 800		

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0 800	Continued From page 31 Supervisor (MS)-E, it was observed that that the door magnet for the fire door to the dining room was missing and the door was propped open with a door wedge. Door magnets release the door from the open position in the event of a fire and allow it to close to protect the occupants and to contain the spread of fire. On the same tour, it was also observed that the cover was missing from an electrical junction box in the ceiling of the utility room in the northwest wing. These deficient conditions were visually verified by MS-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 32 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 28, 2022, at approximately 12:45 p.m. with	0 810		

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0 810	Continued From page 33 Maintenance Supervisor (MS)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan did not have employee actions to be taken in the event of a fire or similar emergency. During interview, MS-E stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, MS-E stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, MS-E stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, MS-E stated that the licensee provides training to employees on fire safety annually to their best knowledge. MS-E was not able to provide a policy on this. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 900	Continued From page 34	0 900		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 28, 2022, at approximately 9:35 a.m. during the entrance conference licensed assisted living director/registered nurse (LALD/RN)-A stated all 33 residents residing at the facility received services under the assisted living with dementia care licensure. R1 and R2's record lacked evidence an assisted living contract had been signed prior to receiving services under the assisted living with dementia care licensure beginning August 1, 2021. R1 began receiving services under the assisted living with dementia care licensure on August 1, 2021. R1's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, identified services provided included dressing and grooming assist, medication management, blood	0 900		

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0 900	Continued From page 36 glucose monitoring, bathing, toileting and transferring assistance. R1's Resident Agreement was dated April 4, 2017. Attached was "[The licensee] Lease Addendum for Assisted Living License 2021" dated September 8, 2021. R1's record lacked evidence an assisted living with dementia care contract was signed prior to receiving services on August 1, 2021, when services began. R2 R2 began receiving services under the assisted living with dementia care licensure on August 1, 2021. R2's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, identified services provided included medication management, blood glucose monitoring, bathing, and Ted hose assistance. R2's Resident Agreement was dated February 1, 2021. Attached was "[The licensee] Lease Addendum for Assisted Living License 2021" dated October 1, 2021. R1's record lacked evidence an assisted living with dementia care contract was signed prior to receiving services on August 1, 2021, when services began. On March 30, 2022, at 11:30 a.m. LALD/RN-A stated a new contract had not been signed by residents previously served under the comprehensive license. Instead, the "[the licensee] Lease Addendum for Assisted Living License 2021" document had been provided and signed by the residents. LALD/RN-A confirmed these were not completed prior to August 1, 2021, when the licensee began providing services under the assisted living with dementia care	0 900		

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0 900	Continued From page 37 licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for three of three employees (licensed assisted living director/registered nurse (LALD/RN)-A, unlicensed personnel (ULP-B and ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	01460		

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01460	Continued From page 38 portion or all of the residents). The findings include: LALD/RN-A started providing services under the comprehensive home care license on February 15, 2016, and under the assisted living with dementia care license on August 1, 2021. LALD/RN-A employee file did not contain documentation of completed orientation to assisted living bill of rights and assisted living facility licensing requirements and regulations before providing assisted living services to residents ULP-B started providing services under the comprehensive home care license on May 14, 2021, and under the assisted living with dementia care license on August 1, 2021. ULP-B's employee file did not contain documentation of completed orientation to assisted living bill of rights and assisted living facility licensing requirements and regulations before providing assisted living services to residents On March 28, 2022, at 12:06 p.m. unlicensed personnel (ULP)-B was observed administering oral medications, checking blood glucose, and administering insulin. ULP-C started providing services under the comprehensive home care license on July 7, 2021, and under the assisted living with dementia care license on August 1, 2021. ULP-C's employee file did not contain documentation of completed orientation to assisted living bill of rights and assisted living facility licensing requirements and regulations before providing assisted living services to residents	01460		

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GOLDEN HORIZONS OF WORTHINGTON	1790 COLLEGEWAY WORTHINGTON, MN 56187

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01460	Continued From page 39 On March 30, 2022, at 11:51 a.m. ULP-C was observed checking blood glucose, administering insulin, and administering other medications to residents. The licensee's Orientation for Assisted Living Staff policy dated August 8, 2021, identified "All facility staff providing, and supervising resident services must complete an orientation to Assisted Living requirements and regulations before providing services to residents. All staff must be trained by means of computer-based training and on the job training. All staff must be competent in the provision of services consistent with current practice standards and appropriate to client needs." "The orientation must contain" included, but not limited to the following topics; -An overview of the appropriate Assisted Living Rules Under Sections 144G.42, 144G.60-144G.64, 144G.82 and 44G.83. -Minnesota Assisted Living Bill of Rights under section 144G.63. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	01610		

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01610	Continued From page 40 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's progress note dated October 25, 2021, at 5:16 p.m. identified R3 had been admitted. R3's pre-admission/admission assessment was dated as completed on October 27, 2021. It identified R3 received assistance with bathing, dressing, toileting assist, medication management and administration.	01610		

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01610	Continued From page 41 R3's service plan dated February 15, 2022, identified R3 received assistance with bathing, dressing, toileting assist, behavior management, medication management and administration. On March 31, 2022, at 9:30 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R3 was admitted on October 25, 2021, as the progress note identified. R3's assessment either was started and not completed until October 27, 2021, or the assessment had not been completed timely. Assessments should be completed according to the policy. The licensee's Assessment - Schedules policy dated March 18, 2020, identified a "Pre-Assessment" was to be completed prior to admission by a registered nurse (RN). It was to be completed in person in the client's residence or remote accommodations in the event in-person is not possible. An "Initial Individualized Assessment" was to be completed by an RN prior to or on day of admission, in person in the client's residence. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 42 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure ongoing comprehensive assessments were completed every 90 days for two of three residents (R1 and R2) and failed to complete a change in condition assessment was completed for one of one resident (R12) with record reviewed. 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 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:	01620		

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01620	Continued From page 43 R1 R1's service plan dated February 15, 2022, identified she received assistance with bathing, dressing, toileting, medication management, and oxygen management. R1's last two Clinical Update Assessments were dated October 25, 2021, and January 25, 2022. There was 92 days between the two assessments. R2 R2's service plan dated February 15, 2022, identified she received assistance with bathing, toileting, and medication management. R2's last two Clinical Update Assessments were dated October 25, 2021, and January 25, 2022. There was 92 days between the two assessments. On March 31, 2022, at 9:30 a.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed R1 and R2's assessments had not been completed within 90 days. The assessments should have been completed per policy. R12 R12's service plan was requested but was not provided. R12's Clinical Update Assessment dated December 9, 2021, identified she received transfer assist of one with a transfer belt. R12's "Fall Nurse Note" dated January 26, 2022,	01620		

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01620	Continued From page 44 at 5:25 a.m. identified "RN alerted by staff resident was on the floor. Slipped from EZ Stand (lifts the patient from a sitting position to a standing position, allowing for transfers to/from the bed or chair. The patient must have the ability to bear weight on at least one leg) harness just as he was bringing her to her recliner from the bathroom. Sustained 4 skin tears on right hand/wrist, no other injuries apparent." On April 1, 2022, at 12:07 p.m. LALD/RN-A stated R12 had increasing difficulty with transfers prior to hospitalization. She was unaware if staff had been using the EZ-Stand; however, she felt a Hoyer lift (an assistive medical device that is a portable patient floor lift which typically uses electric, hydraulic, or battery power, and specialized sling-style pads that slide under the user's body to securely and comfortably transfer an individual requiring 90% - 100% assistance to move from a bed to a wheelchair, toilet, or chair) would have been appropriate at the time of transfer. After review of the Fall Nurse Note that stated staff had used an EZ stand, LALD/RN-A stated after a fall and with use of a mechanical lift, a change in condition comprehensive assessment and new service plan should have been completed, but it had not been done. The licensee's Assessment - Schedules policy dated March 18, 2020, identified ongoing client monitoring and reassessment was to be completed by a registered nurse or a licensed practical nurse at least every 90 days. Changes in client condition were to be completed by a RN as indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

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01620	Continued From page 45 (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. 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 (R12) service plan was revised to reflect the current services provided after a change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 46 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: R12's service plan was requested but was not provided. R12's Clinical Update Assessment dated December 9, 2021, identified she received transfer assist of one with a transfer belt. R12's "Fall Nurse Note" dated January 26, 2022, at 5:25 a.m. identified "RN alerted by staff resident was on the floor. Slipped from EZ Stand (lifts the patient from a sitting position to a standing position, allowing for transfers to/from the bed or chair. The patient must have the ability to bear weight on at least one leg) harness just as he was bringing her to her recliner from the bathroom. Sustained 4 skin tears on right hand/wrist, no other injuries apparent." On April 1, 2022, at 12:07 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R12 had increasing difficulty with transfers prior to hospitalization. She was unaware if staff had been using the EZ-Stand; however, she felt a Hoyer lift (an assistive medical device that is a portable patient floor lift which typically uses electric, hydraulic, or battery power, and specialized sling-style pads that slide under the user's body to securely and comfortably transfer an individual requiring 90% - 100% assistance to move from a bed to a wheelchair, toilet, or chair) would have been appropriate at the time of	01640		

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01640	Continued From page 47 transfer. After review of the Fall Nurse Note that stated staff had used an EZ stand, LALD/RN-A stated after a fall and with use of a mechanical lift, a change in condition comprehensive assessment and new service plan should have been completed, but it had not been done. The licensee's Service Plan policy dated September 1, 2020, identified "An individualized service plan, designed to meet the specific needs of the individual tenant, will be developed based on a nurse evaluation." "The individualized service plan will include, a. The tenants identified needs and preferences for assistance b. The service being provided, frequency, service provider, and charge for service c. Any services and cares to be provided pursuant to the occupancy agreement d. The service providers, other than the Golden Horizons, and what services they provide." "Service plans will be developed, reviewed, and/or updated a. Prior to admission or at the time if admission b. Following 14 days of occupancy c. At least every 90 calendar days d. With a significant change in condition e. Annually" "Upon development of or modification to the service plan at any time, a facility representative and the tenant or the tenant's legal representative, shall sign and date the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01750	Continued From page 48	01750		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications not administered were documented as not administered and the reason they were not administered for one of one resident (R11). In addition, staff failed to complete an air shot prior to administering insulin from an insulin pen for one of one resident (R1) observed during two separate observations. 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 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:	01750		

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01750	Continued From page 49 On March 28, 2022, at 12:44 p.m. review of the medication cart in memory care with unlicensed personnel (ULP)-C, identified two unlabeled medication cups with pills located in the top drawer of the medication cart. ULP-C stated she believed the one medication cup belonged to R3 because they "looked like his medications" and sometimes he refuses them. She was unaware of when those medications were placed there. ULP-C further stated the other medication cup belonged to R11. During the weekend prior, ULP-C stated she brought the medications into R11's room and left them for R11 to take. ULP-C later returned to the room and noted the medications had not been taken. Since it was too late to administer the medications, she removed them from the room and placed them in the top of the mediation cart. On March 29, 2022, at 10:55 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated medication should be administered immediately after it is set up. If for some reason it is not administered as ordered, it should be brought to her for disposal. If nursing is not available, it should be locked in the medication cupboard in the med room for destruction with a note of what the medication is and why it was not given. Staff should not leave medication set up in the medication cart as it creates a risk of the medications being administered to the wrong person. In addition, staff are to always watch the resident take the medications before leaving the room. Especially in memory care they should not leave medications in a resident room as it is a danger of the medications being taken by a wandering resident and memory care residents will forget to take the medication.	01750		

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01750	Continued From page 50 On March 28, 2022, at 12:06 p.m. ULP-B checked R1's blood glucose. Blood glucose test results were 258. ULP-B notified LALD/RN-A instructed her to administer a total of 31 units of Novolog insulin. ULP-B placed a needle on the NovoLog FlexPen, dialed the pen to 31, then injected the insulin into the abdomen. She waited approximately 10 seconds and removed it. ULP-B then removed and disposed the needle. ULP-B failed to dial the pen to two and perform an air shot on the insulin pen prior to administration as recommended in the manufacturer directions for NovoLog FlexPen. On March 30, 2022, at 11:51 a.m. ULP-C went to R1's room and checked her blood glucose with a result of 148. She notified LALD/RN-A who instructed her to give the 22 units scheduled NovoLog insulin. ULP-C dialed the pen to 22. She removed the cap and stated she checked to see if there was a dot of insulin on the tip of the needle, she then injected the insulin into R1's abdomen and waited for approximately 10 seconds. She failed to dial the pen to two and perform an air shot on the insulin pen prior to administration as recommended in the manufacturer directions for NovoLog FlexPen. On March 31, 2022, at 8:36 a.m. LALD/RN-A stated staff were to perform the airshot prior to administration of insulin. She was unaware the facility policy did not include the airshot. Staff were trained through online training which instructs them to perform the airshot. The Licensee's Insulin policy dated March 18, 2020, failed to identify an air shot is to be completed prior to administration of insulin with an insulin pen.	01750		

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01750	Continued From page 51 NovoLog FlexPen manufacturer directions, dated January 2019, identified step 3 is to perform an air shot. It instructs "For each injection: 1. Select a dose of 2 units 2. Take off the outer needle cap (save it) and inner needle cap (throw it away) 3. With the pen pointing up, tap the insulin to move the air bubbles to the top 4. Press the button all the way in and make sure insulin comes out of the needle - Repeat up to two more times with the same needle if needed - If insulin does not come out after three times, change the needle and try again - If insulin still does not come out after changing the needle, the pen may be broken". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 52 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications not administered were documented as not administered and the reason they were not administered for one of one resident (R11). 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 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: On March 28, 2022, at 12:44 p.m. review of the medication cart in memory care with unlicensed personnel (ULP)-C, identified two unlabeled medication cups with pills located in the top drawer of the medication cart. ULP-C stated she believed the one medication cup belonged to R3 because they "looked like his medications" and sometimes he refuses them. She was unaware of when those medications were placed there. ULP-C further stated the other medication cup belonged to R11. During the weekend prior, ULP-C stated she brought the medications into R11's room and left them for R11 to take. ULP-C later returned to the room and noted the medications had not been taken. Since it was too late to administer the medications, she removed them from the room and placed them in the top of the mediation cart.	01760		

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01760	Continued From page 53 R11's March 2022 medication administration record identified lacked documentation the following medications were administered or not administered, and reason why they were not administered, on March 27, 2022: - Eliquis 5 mg (milligrams) take 1 tablet by mouth 2 times a day (blood thinner) - Miralax mix 17 grams with water every day (constipation) - Preservision AREDS administer two capsules by mouth daily (eye health) - sotalol take one tablet twice daily by mouth (treats heart rhythm problems) On March 29, 2022, at 10:55 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated medication should be administered immediately after it is set up. If for some reason it is not administered as ordered, it should be brought to her for disposal. If nursing is not available, it should be locked in the medication cupboard in the med room for destruction with a note of what the medication is and why it was not given. Staff should have documented the medications had not been administered and why it had not been administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 54 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one medication cart, in the memory care unit, was securely locked in substantially constructed compartments and permitted only authorized personnel to have access with records reviewed. This had the potential to affect all 12 of 12 residents residing in the memory care unit. 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 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: During a facility tour on March 28, 2022, at 11:10 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A upon entry to the memory care unit, the medication cart was noted to be unlocked in the hallway next to the staff office. No staff were present near or within sight of the medication cart. R14 was noted in the hallway near the cart. Upon questioning LALD/RN, she stated it should be locked, she locked the cart, and instructed unlicensed personnel (ULP)-C that the cart should be locked at all times. The licensee's Storage of Medications policy	01880		

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01880	Continued From page 55 dated March 18, 2020, identified "[The facility] stores medication in a safe and secure manner that prevents diversion and is only accessible to designated staff and contractors of [the facility]." "[The facility] stores client's medications in 'Click or tap here to enter text.' Stored medications are kept locked at all times other than while a staff person is present at the time of medication administration or medication management." No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened and had a pharmacy label for three of four residents (R6, R15, and R1) with insulin, and 2 of 2 residents (R16 and R13) with eye drops, with records reviewed. The licensee failed to ensure medication that was not administered and was no longer in the original container, labeled by the pharmacy, was placed in a separate area for destruction. The licensee failed to ensure the pharmacy label matched the physician orders for	01890		

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01890	Continued From page 56 one of five residents (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Failed to ensure time sensitive medications were dated when opened and had a pharmacy label On March 28, 2022, at 11:57 a.m., review of a locked medication refrigerator in the medication room with unlicensed personnel (ULP)-B, identified the following: - R6 had an opened and in use Byetta (lowers blood sugar) injection pen. No open or expiration date noted on pen. - R15 had opened and in use NovoLog (lowers blood sugar) FlexPen and Basaglar KwikPen (lowers blood sugar.) No open or expiration date noted on the pens. - R1 had an open and in use NovoLog FlexPen and Levemir (lowers blood sugar) FlexTouch pen. No open or expiration date noted on the pens. ULP-B confirmed there was no open date was noted on the pens. She stated when staff start a new pen, they are to put the open date on the pen. On March 28, 2022, at 12:44 p.m. review of the medication cart in memory care with ULP-C, identified the following: - R16 had an open and in use bottle of latanoprost (glaucoma). No open or expiration date noted on the bottle.	01890		

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01890	Continued From page 57 - R13 had an open and in use bottle of Dorzolamide/Timolol (glaucoma) eye drops. No pharmacy label was noted on the bottle. A partial tag with open date had "22" on it. ULP-C confirmed there were no open dates on the eye drops and the label was missing on R13's Dorzolamide/Timolol eye drops. She stated the label should be on the bottle and staff were to label the bottle with the date it was opened. On March 29, 2022, at 10:55 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated medications that are time sensitive should be labeled with the date opened and should be out of use after the beyond use date. The staff has access to a cheat sheet that was received form the pharmacy, that they are to follow. After surveyor requested the pharmacy cheat sheet during the interview with LALD/RN-A, the licensee provided a list titled "Beyond Use," date received by fax March 29, 2022, that identified the following - Latanoprost 6 weeks - All other eye drops/ointments 28 days - Basaglar pen 28 days - Levemir pen 42 days - Novolog pen 28 days - Byetta 30 days Failed to ensure medication that was not administered and was no longer in the original container, labeled by the pharmacy, was placed in a separate area for destruction. On March 28, 2022, at 12:44 p.m. review of the medication cart in memory care with ULP-C identified two medications cups with pills in them, were unlabeled in the top drawer of the	01890		

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01890	Continued From page 58 medication cart. ULP-C stated she believed the one medication cup belonged to R3 because they "looked like his medications" and sometimes, he refused them. She was unaware of when those medications were placed there. She stated the other medication cup belonged to R11. During the weekend prior, ULP-C stated she brought the medications into R11's room and left them for R11 to take. ULP-C later returned to the room and noted the medications had not been taken. Since it was too late to administer the mediations, she removed them from the room and placed them in the top of the medication cart. On March 29, 2022, at 10:55 a.m. LALD/RN-A stated medication should be administered immediately after it is set up. If for some reason it was not administered as ordered, it should be brought to her for disposal. If nursing was not available, it should be locked in the medication cupboard in the med room for destruction with a note of what the medication was and why it was not given. Staff should not leave medication set up in the medication cart as it creates a risk of the medications being administered to the wrong person. In addition, staff were to always watch the resident take the medications before leaving the room. Especially in memory care they should not leave medications in a resident room as it is a danger of the medications being taken by a wandering resident and memory care residents will forget to take the medication. Staff should have documented the medications had not been administered and why it had not been administered. Failed to ensure the pharmacy label matched the physician orders On March 28, 2022, at 12:28 p.m. ULP-B was	01890		

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01890	Continued From page 59 observed to set up medications for R7. R7's March 2022, medication administration record (MAR) identified "duo-neb [opens lungs for breathing ease] (Daily) 2.5-0.5 mg (milligrams)/3 ml (milliliters) administer duo-neb by nebulizer machine 4x daily." R7's pharmacy label for DuoNeb identified "DuoNeb inhale 1 ampule nebulizer every 8 hours as needed for shortness of breath." ULP-B stated the MAR and the pharmacy label should match, but they go by what is on the MAR. ULP-B further stated "nobody really reads the label" except to ensure the right person and right medications. She took out one ampule of medication and placed it in the nebulizer cup and instructed R7 it was ready for him. She then documented the administration. R7's physician orders signed March 8, 2022, identified "duo-neb (Daily) 2.5-0.5 mg (milligrams)/3 ml (milliliters) administer duo-neb by nebulizer machine 4x daily." On March 31, 2022, at 11:32 a.m. LALD/RN-A stated the pharmacy label and the MAR should match and if it did not, staff were to call the RN. The licensee's Storage of Medication policy dated March 18, 2020, identified "All Medications are stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." The licensee's Medication, Treatment and Therapy Administration by Unlicensed Personnel policy dated March 16, 2020, identified "Unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and	01890		

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01890	Continued From page 60 competency tested by the RN on the following: a. The complete procedures for checking the client's medication administration record and medication profile, treatment and therapy profile and any additional information. b. Infection control precautions that must be followed when administering medications, treatment and therapy. c. Preparation of the medication for the client when necessary; d. Administration of the medication, treatment and therapy to the client (or assistance with self-administration); e. Documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our agency's procedures for documenting the MAR. f. The procedure for staff to notify the RN of any medications or dietary supplements that are being used by the client and that are not included in the assessment for med management services.." The licensee's Medication Record - Documentation policy dated March 18, 2020, identified "2) If medication assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided". Byetta's Pen User Manual undated, identifies "You can use your BYETTA Pen for up to 30 days after setting up a new pen for first use. After 30 days, throw away the BYETTA Pen, even if it is not completely empty." NovoLog FlexPen manufacturer directions dated February 2015, identified "The NovoLog	01890		

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01890	Continued From page 61 FlexTouch Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." Basaglar KwikPen instructions for use dated July 2021, identified "Throw away the Pen you are using after 28 days, even if it still has insulin left in it." Levemir FlexTouch pen prescribing information dated January 2019, identified "The Levemir FlexTouch Pen you are using should be thrown away after 42 days, even if it still has insulin left in it." Latanaprost manufacturer directions dated September 16, 2014, identified "must be used within 28 days after opening the bottle. Discard the bottle and/or unused contents after 28 days." Dorzolamide/Timolol Manufacturer directions dated January 2020, identified "Discard Dorzolamide / Timolol 28 days after first opening." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a prescription for blood glucose	01900		

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01900	Continued From page 62 test strips for one resident was not being used for another resident with blood glucose monitoring. 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: On March 28, 2022, at 12:06 p.m. unlicensed personnel (ULP)-B administered oral medications to R1 and asked her to go to her room so she could check her blood sugar. ULP-B went to R1's room, applied gloves, opened medication drawer, and noted there were no blood glucose test strips in the drawer. She then removed her gloves and went to check with the nurse. ULP-B returned to the room carrying a single test strip, stating she found one. She put on gloves and completed blood glucose testing and removed gloves. After exiting the room, ULP-B stated she "borrowed" the test strip from R2. ULP-B further stated staff failed to order the test strips over the weekend, and she needed to check R1's blood glucose. ULP-B stated that sometimes they borrow from another resident as long as they replace it later. On March 30, 2021, at 11:30 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated staff should not have borrowed a test strip from another resident. They should have notified her because she could have replaced the "FreeStyle Libre" (continuous glucose monitoring device) sensor. In addition, a	01900		

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01900	Continued From page 63 box of strips was in the cupboard behind another item, and ULP-B was not able to see it. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the	01910		

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01910	Continued From page 64 medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5 began receiving assisted living services on February 17, 2021. R5's Service Plan dated February 17, 2021, indicated R5 received services, which included bathing, grooming, dressing, and medication administration. R5's Progress Notes dated February 28, 2021, at 3:11 p.m. identified "Residents daughter is moving in to assist mother and father so she is discharging home today. Her medications will be sent with her. Husband is here to help her move and collect belongings. MD is aware as they just returned from appointment. " R5's record lacked evidence of a disposition of medications. On March 29, 2022, at 10:40 a.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed no disposition of medications had been completed. She was unaware of the requirement. She stated the	01910		

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01910	Continued From page 65 licensee did not have a policy regarding disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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(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
02040	Continued From page 66 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 28, 2022, at approximately 12:45 p.m. with Maintenance Supervisor (MS)-E on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, MS-E stated they were not aware of a hazard vulnerability assessment being performed for the physical environment for the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	04/01/2022

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02240	Continued From page 67 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the assisted living bill of rights to two of two residents (R1 and R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02240	Continued From page 68 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: On March 28, 2022, at approximately 9:35 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated all 33 residents residing at the facility received services under the assisted living licensure. R1 and R2's record lacked signed acknowledgement they had received the assisted living bill of rights. R1 R1 began receiving services under the assisted living licensure on August 1, 2021. R1's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, identified services provided included dressing and grooming assist, medication management, blood glucose monitoring, bathing, toileting and transferring assistance. R1's "2022 Documents Update" signed January 4, 2022, included the assisted living bill of rights as a document received by R1; however, R1's record lacked evidence she had received the assisted living bill of rights on August 1, 2021, when services began under the assisted living licensure. R1's "[The licensee] Lease Addendum for	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	04/01/2022

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02240	Continued From page 69 Assisted Living License 2021" signed September 8, 2021, lacked evidence the assisted living bill of rights had been provided to R1. R2 R2 began receiving services under the assisted living licensure on August 1, 2021. R2's "Service Plan (Waiver)-Addendum to Contract" dated February 15, 2022, identified services provided included medication management, blood glucose monitoring, bathing, and Ted hose assistance. This identified she received the assisted living bill of rights at that time; however, R2's record lacked evidence she had received the assisted living bill of rights on August 1, 2021, when services began under the assisted living licensure. R2's "[The licensee] Lease Addendum for Assisted Living License 2021" dated October 1, 2021, lacked evidence the assisted living bill of rights had been provided to R2. On March 30, 2022, at 11:30 a.m. LALD/RN-A stated a new contract had not been signed by residents previously served under the comprehensive license. Instead, the "[The licensee] Lease Addendum for Assisted Living License 2021" document had been provided and signed by the residents. LALD/RN-A confirmed this did not include the assisted living bill of rights. The licensee's Bill of Rights policy dated March 18, 2020, identified "[the licensee] shall provide the client or the client's representative a written copy of the Minnesota Bill of Rights (BOR) before the initiation of services to that client." "[the	02240		

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02240	Continued From page 70 licensee shall obtain written acknowledgment of the client's receipt of the BOR or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of BOR receipt shall be retained in the client's record." The policy did not identify the required assisted living bill of rights since August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=G	144G.91 Subd. 4 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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R10) with bedrails, with record reviewed. This resulted in an immediate correction order on March 29, 2022, at 4:10 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	02310		

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02310	Continued From page 71 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Alzheimer's disease, anxiety, insomnia and nocturia. R1's service plan dated January 7, 2022, indicated R1 received assistance with medication management, dressing, grooming, bathing, meals, and safety checks. R1's Clinical Update Assessment dated March 15, 2022, identified R10 currently used a "hand bar to assist with bed mobility." It also identified the device met the 2006 FDA recommendations for bed safety; however, the assessment failed to include measurements. On March 29, 2022, at 3:00 p.m. the device was on the left side near the head of R10's bed. March 29, 2022, at 3:06 p.m. licensed assisted living director/registered nurse (LALD/RN)-A completed measurements for R1's siderail with the surveyor present. The bed rail opening was found to be 18 inches wide and 5.5 inches high, which did not meet FDA guidelines (zone 1). R1's record also lacked evidence the risks and benefits of siderail use had been explained to the resident and/or resident's representative. On March 29, 2022, at 4:15 p.m. LALD/RN-A confirmed all of the information above. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1	02310		

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02310	Continued From page 72 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised 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 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 licensee's Siderails policy dated March 18, 2020, read "When [the licensee] is aware a home care client is utilizing siderails (a medical device) on a bed, [the licensee] shall assess the use, educate the client, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the siderail. When siderails are in use, the RN shall conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. If the siderail is acting as a restraint, appropriate action should be taken. Staff from [the facility] shall determine if the side rail is considered to be safe. 'Safe' shall be defined as meeting all of the requirements listed below: -The siderail is used consistent with manufacturer's directions. Be aware of siderails that slide between the mattress and box spring	02310		

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02310	Continued From page 73 designed for toddler use. -The siderails are installed securely and maintained in good operating condition. Be aware of 'wobbly' siderails. -The siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means siderail zones 1,2, and 3 must not exceed 4.75." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 30, 2022, at 9:22 a.m. the immediacy of correction order 2310 was removed; however, non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the	03090		

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03090	Continued From page 74 establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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: On March 28, 2022, at approximately 10:15 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. During a facility tour on March 28, 2022, at approximately 11:10 a.m. with licensed assisted living director/registered nurse (LALD/RN)-A, confirmed there was no postings for electronic monitoring at facility entrances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *03/31/22*
Time: 13:30:11
Report: 1028221058

Food and Beverage Establishment Inspection Report

Location:
Golden Horizons of Worthington
1790 Collegeway
Worthington, MN56187
Nobles County, 53

Establishment Info:
ID #: 0026251
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
KC Companies of Worthington In

Phone #: 5073763111
ID #: 34406

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

The following orders were issued during this inspection.

2-300 Personal Cleanliness

2-301.15 ** Priority 2 **

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

The handwashing soap dispenser, handwashing poster, and paper towels must be removed from the prep sink area.

Comply By: 04/04/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

Provide a test kit for the quaternary ammonium sanitizer.

Provide a test kit for the hot water dish machine.

Comply By: 04/04/22

2-100 Supervision

2-102.12AMN

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

A Certified Food Protection Manager must be employed by this establishment as soon as possible.

Comply By: 04/04/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

The built-in steam table must be repaired as it is no longer functioning correctly.

Comply By: 06/30/22

4-500 Equipment Maintenance and Operation

4-502.11C

MN Rule 4626.0820C Ambient air temperature, water pressure, and water temperature measuring devices must be accurate within the intended range of use and maintained in good repair.

The internal thermometer for the kitchenette display cooler must be replaced as it is no longer functioning.

Comply By: 04/04/22

Surface and Equipment Sanitizers

Hot Water: = at 195 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: True - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: Hoshizaki - Ambient
Violation Issued: No

Process/Item: Cooling
Temperature: 49 Degrees Fahrenheit - Location: Chicken Noodle Soup
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: Tuna
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: -5 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

No Follow-Up Inspection is needed at this time.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221058 of 03/31/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____

Louise Claussen
Cook

Signed: 

Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us

Report #: 1028221058

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Dept. of Health

Mankato

No. of RF/PHI Categories Out	2	Date	03/31/22
No. of Repeat RF/PHI Categories Out	0	Time In	13:30:11
Legal Authority MN Rules Chapter 4626		Time Out	

Golden Horizons of Worthington	Address: 1790 Collegeway	City/State: Worthington, MN	Zip Code: 56187	Telephone: 5073763111
License/Permit #: 0026251	Permit Holder: KC Companies of Worthington In	Purpose of Inspection: Full	Est Type:	Risk Category: H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Surpervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O Plant food properly cooked for hot holding		
35		IN OUT N/A N/O Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/04/22

Inspector (Signature)