DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

September 7, 2022

Administrator
Golden Horizons Of Cross Lake
13631 East Shore Road
Cross Lake, MN 56442

RE: Project Number(s) SL30621015

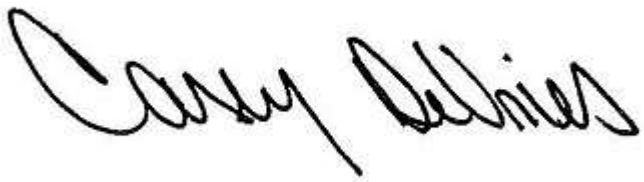
Dear Administrator:

On August 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 25, 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,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

June 21, 2022

Administrator
Golden Horizons Of Crosslake
13631 East Shore Road
Cross Lake, MN 56442

RE: Project Number SL30621015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 25, 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00**

**The total amount you are assessed is $3,000.00**. 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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 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 |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL30621015-0<br><br>On May 23, 2022, through May 25, 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 25 residents, all who received services under the provider's Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required | 0 110 | | |

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| 0 110 | Continued From page 1<br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On May 23, 2022, at approximately 11:40 a.m., during the entrance conference, licensed assisted living director (LALD)-C identified herself as the LALD for the facility.<br><br>LALD-C obtained an assisted living director license on July 21, 2021.<br><br>On May 23, 2022, at 1:08 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-C held a current assisted living director license. The BELTSS website did not indicate LALD-C was listed as the Director of Record for the licensee. | 0 110 | | |

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| 0 110 | Continued From page 2<br><br>On May 23, 2022, at 2:40 p.m., LALD-C confirmed her name was not listed as the Director of Record for licensee as she was newer to the position.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. | 0 480 | | |

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| 0 480 | Continued From page 3<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated May 23, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, | 0 490 | | |

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| 0 490 | Continued From page 4<br>and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs posted and available to residents and visitors. This had the potential to affect nine residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On May 23, 2022, and May 24, 2022, the surveyor observed no activities were planned in the memory unit. Some residents remained in their rooms or were stationed in front of the television in the common area of the unit. In addition, there was not a daily program posted on the unit.<br><br>On May 24, 2022, at 8:15 a.m., Activity Director (AD)-F verified there was not an activity calendar posted on the unit adding "they just keep ripping them down." | 0 490 | | |

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| 0 490 | Continued From page 5<br><br>The licensee's Activities policy dated September 1, 2020, indicated [the facility] offered appropriate planned and spontaneous activities for its residents. A written schedule of activities would be developed, publicly posted in the common area, and accessible to residents and their legal representatives.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 490 | | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R2, R3).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 630 | | |

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| 0 630 | Continued From page 6<br>safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1<br>R1's diagnoses included hypertension, obstructive sleep apnea and arthritis.<br><br>R1's service plan dated May 24, 2022, indicated the resident received services which included medication administration, C-pap (continuous positive airway pressure) assistance and cleaning, and vitals.<br><br>R1's Individual Abuse Prevention Plan (IAPP) dated May 24, 2022, did not include an assessment of the person's susceptibility to abuse by another individual, the person's risk of abusing other vulnerable adults, or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>On May 25, 2022, at 11:45 a.m., registered nurse (RN)-H verified R1's IAPP did not include the required content. The same form was used for all residents.<br><br>R2<br>R2's diagnoses included amputation, above the knee left lower extremity, diabetes mellitus type II, history of stroke, depression, anxiety and suprapubic catheter.<br><br>R2's unsigned service plan dated May 24, 2022, | 0 630 | | |

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| 0 630 | Continued From page 7<br>indicated the resident received services which included medication administration, blood glucose recording, bathing assist, behavior assist, brace assist, catheter care, dressing, grooming, toileting, and vitals.<br><br>R2's IAPP dated May 24, 2022, did not include an assessment of the person's susceptibility to abuse by another individual, the person's risk of abusing other vulnerable adults, or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>R4<br>R4's diagnoses included traumatic brain injury (TBI), Lewy Body Dementia, high blood pressure, and osteoarthritis of knees.<br><br>R4's unsigned service plan dated May 23, 2022, indicated the resident received services which included medication management, transfer assist, bathing assist, dressing assist, grooming assist, assistive device reminder, fall prevention, toileting assist, monitoring for edema, and vital signs.<br><br>R4's IAPP dated May 24, 2022, did not include an assessment of the person's susceptibility to abuse by another individual, the person's risk of abusing other vulnerable adults, or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>On May 24, 2022, at 12:44 p.m. RN-G verified R2 and R4's IAPP's did not include the required content and the same form was used for all residents.<br><br>No further information was provided. | 0 630 | | |

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| 0 630 | Continued From page 8<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel | 01440 | | |

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| 01440 | Continued From page 9<br>((ULP)-D and ULP-E).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>ULP-D<br>On May 24, 2022, at 7:42 a.m., the surveyor observed ULP-D using a finger prick method to draw blood to check R5's blood glucose and administer R5's morning medications.<br><br>ULP-D was hired on April 5, 2022, to provide direct care services to residents at the assisted living facility. ULP-D's employee record lacked documentation a registered nurse (RN) supervised ULP-D performing a delegated task within 30 days of beginning work with the licensee.<br><br>ULP-E<br>On May 24, 2022, at 8:00 a.m., the surveyor observed ULP-E administer medications to R1.<br><br>ULP-E was hired on October 21, 2021, to provide direct care services to residents at the assisted living facility. ULP-E's 30-day supervision was dated February 22, 2022.<br><br>On May 24, 2022, at 10:30 a.m., Director (D) -A confirmed ULP-D's 30-day supervision of delegated tasks had not been completed and it should have been, "I have a stack on them in my | 01440 | | |

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| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
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| 01440 | Continued From page 10<br>office." D-A also confirmed ULP-E's 30-day supervision was not completed within 30 days as required.<br><br>The licensee's Supervision of Unlicensed Staff policy dated March 18, 2020, verified the RN would supervise ULP within 30 days after the individual began working for the provider.<br><br>No further information as provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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 from the last date of the assessment.<br>(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.<br>(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 | 01620 | | |

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| 01620 | Continued From page 11<br>facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring on or before day 90 for one of three residents (R4) as required.<br><br>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).<br><br>The findings include:<br><br>On May 23, 2022, at 11:45 a.m., during the entrance conference, Director (D)-A and RN-B stated the licensee completed assessments upon admission, at 14 days, every 90 days and with changes in condition.<br><br>R4 began receiving assisted living services on March 12, 2014.<br><br>R4's diagnoses included traumatic brain injury (TBI), Lewy Body Dementia, high blood pressure and osteoarthritis of knees.<br><br>R4's unsigned service plan dated May 23, 2022, indicated the resident received the following services: medication management, transfer assist, bathing assist, dressing assist, grooming | 01620 | | |

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| 01620 | Continued From page 12<br>assist, assistive device reminder, fall prevention, toileting assist, monitoring for edema and vital signs.<br><br>R4's record included an assessment dated February 21, 2022, and an assessment dated May 23, 2022, one day after the 90-day assessment was due.<br><br>On May 23, 2022, at 1:34 p.m., RN-G confirmed the 90-day assessment had not been completed timely, as required.<br><br>On May 23, 2022, at 1:35 p.m., RN-B verified the assessment had not been completed on day 90 day since that was on the weekend, adding she thought it would be ok to complete it on Monday.<br><br>The licensee's Assessment-Schedules policy dated March 18, 2020, confirmed the RN would conduct assessments consistent with Minnesota regulation and the individualized needs of each resident, at least every 90 days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting | 01640 | | |

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| 01640 | Continued From page 13<br>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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure one of three residents (R4) service plans was revised to include provided services.<br><br>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).<br><br>The findings include:<br><br>R4's diagnoses included traumatic brain injury (TBI), Lewy Body Dementia, high blood pressure and osteoarthritis of knees. | 01640 | | |

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| 01640 | Continued From page 14<br><br>On May 23, 2022, at 1:47 p.m., the surveyor observed unlicensed personnel (ULP)-I adjust R4's nasal cannula (a hollow tube with two prongs that are placed into the nares to supply oxygen). R4 was sitting in a Tilt-N-Space (reclining) wheelchair with an oxygen cylinder in a holder nearby.<br><br>R4's service plan dated May 23, 2022, did not identify R4 received assist with oxygen.<br><br>On May 24, 2022, at approximately 1:45 p.m., registered nurse (RN)-G verified R4's current service plan lacked information to include oxygen administration.<br><br>The licensee's Service Plans policy dated March 18, 2020, confirmed the service plan would be revised based on the results of required client [resident] monitoring or reassessments. In addition, they would implement and provide all services required by the current service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be | 01690 | | |

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| 01690 | Continued From page 15<br>developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the security and accountability of controlled substances was maintained for three of three residents (R5, R6, R7).<br><br>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 | 01690 | | |

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| 01690 | Continued From page 16<br>the residents).<br><br>On May 23, 2022, at approximately 11:40 a.m., during the entrance conference, registered nurse (RN)-B confirmed the licensee provided medication management services for residents at the facility and some residents had a controlled substance prescribed.<br><br>On May 24, 2022, at approximately 12:30 p.m., the surveyor requested to review the narcotic log (a record where staff document the removal and addition of identified controlled substances) for the locked refrigerator in RN-B's office.<br><br>On May 24, 2022, at approximately 12:35 p.m., the surveyor observed RN-G reviewing and logging the medications stored in the locked refrigerator:<br>- 30 milliliters (ml) Ativan (a medication used to treat anxiety) and 30 ml morphine (a moderate to severe controlled substance pain reliever) for R6;<br>-30 ml Ativan, 27 ml morphine for R7; and<br>-30 ml morphine and 30 ml Ativan for R8.<br><br>On May 24, 2022, at approximately 12:40 p.m., RN- B and RN-G verified the licensee did not have a narcotic log for the medications stored in the locked refrigerator in RN-B's office and staff was not monitoring and/or counting R6, R7 and R8's medications to prevent diversion.<br><br>The licensee's Narcotic Log policy dated September 1, 2020, verified all scheduled II controlled substances must be recorded on an individual page in the bound narcotic logbook, to include:<br>-name of client [resident];<br>-date received;<br>-medication name and strength; | 01690 | | |

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| 01690 | Continued From page 17<br>-quantity received; and<br>-prescriber's name.<br>Additionally, the policy indicated all schedule II controlled substances would be counted and recorded on the narcotic count sheet and compared with the quantities listed in the Narcotic Logbook, and discontinued controlled substances would be counted with the regular narcotic inventory until they could be destroyed according to established medication destruction procedures.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that | 01730 | | |

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| 01730 | Continued From page 18<br>medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R2).<br><br>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).<br>The findings include: | 01730 | | |

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| 01730 | Continued From page 19<br><br>On May 23, 2022, at approximately 10:40 a.m., during the entrance conference, registered nurse (RN)-B confirmed the licensee provided medication management services to residents at the facility.<br><br>R2's diagnoses included amputation, above the knee left lower extremity, diabetes mellitus type 2 (DMII), history of stroke, depression, anxiety, and a suprapubic catheter.<br><br>R2's unsigned service plan dated May 24, 2022, indicated the resident received medication management services.<br><br>R2's electronic medication administration record (EMAR) dated May 2022 included the following medications: pain relievers, cholesterol reducer, seizure medication, medication to reduce the risk of stroke and/or blood clots, DMII medication, cardiac medication, vitamin supplement, a diuretic, an anti-depressant, a bladder relaxant, and an anti-infective.<br><br>R2's Individualized Medication Management Plan dated May 24, 2022, lacked the following:<br>- a description of storage of medications based on the resident's needs and preferences, and consistent with manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel (ULP);<br>- procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management | 01730 | | |

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| 01730 | Continued From page 20<br>services;<br>- any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and<br>-completion of medication reconciliation.<br><br>On May 24, 2022, at approximately 2:00 p.m., RN-G verified R2's Individualized Medication Management Plan did not include all the required content as noted above.<br><br>The licensee's Medication Management Services policy dated March 18, 2020, confirmed the RN would develop an individualized medication management plan to include:<br>a. Statement of the medication management services that would be provided;<br>b. The identification and review of all medication the client [resident] is known to be taking including the medication indications, side effects, contraindication, allergic or adverse reactions and the actions to address these issues;<br>c. Methods of administration, specific instructions, and delegation of tasks to unlicensed personnel;<br>d. Measures and interventions taken to assure proper storage and prevent diversions of medication;<br>e. Provide instructions to the client [resident] or the clients representative on interventions to manage the client's medications and prevent diversion of medication;<br>f. Detail the responsibility for medication reordering and supplies tracking;<br>g. Procedures for staff to notify the RN or appropriate licensed health professional when a problem arises with medication management services; and | 01730 | | |

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| 01730 | Continued From page 21<br>h Any client [resident] specific medication administration documentation specifics, monitoring of medication use to prevent possible complication or adverse reactions, and verification that the medications are administered as prescribed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to maintain one of one medication refrigerator at an acceptable temperature to ensure medications were stored according to manufacturer's recommendations. This had the potential to affect all 25 residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include: | 01880 | | |

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| 01880 | Continued From page 22<br><br>On May 24, 2022, at 12:35 p.m., the surveyor and resigtered nurse (RN)-B reviewed the contents of the locked medication refrigerator which was in RN-B's office. RN-B stated the temperatures for the refrigerator should be monitored and recorded daily adding the log was normally "here" while she tapped with her hand on the front of the refrigerator. RN-B added that it was possible maintenance personnel had the log and was conducting an audit of the refrigerator temperatures. RN-B was unsure of what the acceptable temperature range was for storing medications.<br><br>The refrigerator contained:<br>- 30 milliliters (ml) Ativan (a medication used to treat anxiety), and 30 ml morphine (a moderate to severe controlled substance pain reliever) for R6;<br>- 30 ml Ativan, 27 ml morphine and 15 ml Haldol (used to treat certain mental/ mood disorders) for R7;<br>- 30 ml Ativan, 30 ml morphine and 22 ml Haldol for R8;<br>- a partially used vial of Tubersol (a solution used in a skin test to aid diagnosis of tuberculosis infection (TB); and<br>- a locked box on the bottom shelf of the refrigerator which RN-B stated was not in use and she did not know what key opened it, or if she had the key.<br><br>RN-B provided the surveyor with the Chore Recap by Chore Type document (on-line tracking for tasks/temperature log) for medication refrigerator dated May 1, 2022, through May 25, 2022. 10 out of the 18 times the temperature was recorded as being in the acceptable range of 36 to 46 degrees Fahrenheit (F). However, three times the temperature was recorded at 30 | 01880 | | |

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| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

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| 01880 | Continued From page 23<br>degrees, 1 time it was recorded "less than 30 degree", one time at 29 degrees, one time at 31 degrees and one time at 34 degrees.<br><br>On May 24, 2022, at 2:18 p.m., RN-B confirmed the temperatures should be recorded daily and this was not consistently being done and the temperatures recorded were not always within the acceptable range adding no action had been taken.<br><br>The manufacturer's instructions for Ativan dated April 1, 2022, indicated to store at cold temperature 36 - 46 degrees F.<br><br>The manufacturer's instructions for Morphine dated May 1, 2022, indicated to store at room temperature, away from heat, moisture, and direct light, keep from freezing.<br><br>The manufacturer's instructions for Haldol dated May 1, 2022, indicated to store at room temperature, keep away from heat, moisture, direct light and keep from freezing.<br><br>The manufacturer's instructions for Tubersol dated August 2013, indicated to store at 36 to 46 degrees F and do not freeze.<br><br>The licensee's Storage of Medications policy dated March 18, 2020, indicated all medication would be stored consistent with manufacturer's recommendation (refrigerated, room temperature, or frozen).<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |

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| 01940 | Continued From page 24 | 01940 | | |
| 01940 SS=E | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management | 01940 | | |

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| 01940 | Continued From page 25<br>plan to include the required content for two of three residents (R1, R4).<br><br>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 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).<br>The findings include:<br>On May 23, 2022, at approximately 11:45 a.m., during the entrance conference, registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents as prescribed.<br><br>R1<br>R1's diagnoses included hypertension, obstructive sleep apnea and arthritis.<br><br>R1's Service Agreement dated May 24, 2022, indicated R1 received assistance with a C-PAP (continuous positive airway pressure) machine. R1's record did not include an individual treatment/therapy plan.<br><br>R4<br>R4's diagnoses included traumatic brain injury (TBI), Lewy Body Dementia, high blood pressure and osteoarthritis of knees.<br><br>On May 23, 2022, at 1:47 p.m., the surveyor observed unlicensed personnel (ULP)-I adjust R4's nasal cannula (a hollow tube with two prongs that are placed into the nares to supply oxygen). | 01940 | | |

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| 01940 | Continued From page 26<br><br>R4's unsigned service plan dated May 23, 2022, lacked a written statement of the treatment service the resident received to include oxygen.<br><br>R4's record lacked evidence of an individualized treatment or therapy management plan which included the following for oxygen administration:<br>- a statement of the type of services that would be provided;<br>- documentation of specific resident instructions relating to the treatments or therapy administered;<br>- identification of treatment or therapy tasks that would be delegated to ULP;<br>- procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was administered as prescribed; and monitoring of treatment or therapy to prevent possible complications or adverse reactions.<br><br>On May 24, 2022, at 12:55 p.m., RN-G verified R1 did not have a treatment/therapy plan developed. RN-G stated it was because of a glitch in the RTasks (electronic record) system and she was working on a solution.<br><br>On May 24, 2022, at approximately 2:00 p.m., RN-G verified R4's Individualized Medication Management Plan did not include all the required content as noted above.<br><br>The licensee's Treatment and Therapy Services policy dated March 18, 2020, verified the RN would develop an individualized Treatment and Therapy Service plan including:<br>a. statement of the Treatments and Therapies | 01940 | | |

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| 01940 | Continued From page 27<br>that would be provided;<br>b. frequency of service;<br>c. service providers;<br>d. supervisory services by the RN;<br>In addition, the policy indicated the RN must specify, in writing in the electronic record, specific instruction for each client [resident].<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R4) receiving treatments.<br><br>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 | 01970 | | |

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| 01970 | Continued From page 28<br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On May 23, 2022, at approximately 11:45 a.m., during the entrance conference, registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents as prescribed.<br><br>On May 23, 2022, at 1:47 p.m., the surveyor observed unlicensed personnel (ULP)-I adjust R4's nasal cannula (a hollow tube with two prongs that are placed into the nares to supply oxygen).<br><br>R4's unsigned service plan dated May 23, 2022, lacked a written statement of the treatment service the resident received to include oxygen.<br><br>R4's prescriber's orders dated March 10, 2022, included an inhalation medication for shortness of breath but lacked an order for oxygen.<br><br>On May 24, 2022, at approximately 2:00 p.m., RN-H confirmed R4's record lacked an order for oxygen.<br><br>The licensee's Treatment and Therapy Services policy dated March 18, 2020, indicated, The RN will verify that all the client's treatment and therapy orders have current prescriber's orders on file in their chart.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01970 | | |

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| 02110 | Continued From page 29 | 02110 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. | 02110 | | |

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| 02110 | Continued From page 30<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident and/or the residents legal and designated representative at the time of move-in. This had the potential to affect all residents, staff and visitors.<br><br>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 the residents). The findings include:<br><br>The licensee lacked evidence the following required policies and procedures related to the dementia care had been developed:<br>- philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>- evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>- wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; | 02110 | | |

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| 02110 | Continued From page 31<br><br>- description of life enrichment programs and how activities are implemented;<br>- description of family support programs and efforts to keep the family engaged;<br>- limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>- transportation coordination and assistance to and from outside medical appointments; and<br>- safekeeping of residents' possessions.<br><br>In addition to the above policies, the following policy was not provided to the residents and the residents' legal and designated representative at the time of move-in:<br>- staff training specific to dementia care.<br><br>On May 25, 2022, at 11:45 a.m., registered nurse (RN)-H confirmed the licensee lacked the above required policies and verified none had been provided to the resident or the residents' legal and designated representative.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02110 | | |
| 02140 SS=F | 144G.83 Subd. 3 Supervising staff training<br><br>Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:<br>(1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test | 02140 | | |

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| 02140 | Continued From page 32<br>required by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On May 24, 2022, at 10:50 a.m., licensed assisted living director (LALD)-C stated the facility utilized Educare for dementia training and no staff had completed a competency or knowledge test required in dementia training. LALD-C stated they did not think it was needed since training was done through Educare (online training system).<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) days | 02140 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In | 02170 | | |

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| 02170 | Continued From page 33<br>addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have an evaluation for an activity plan for one of one resident (R4) who received services under an assisted living with | 02170 | | |

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| 02170 | Continued From page 34<br>dementia care license. This affected all residents receiving care under the dementia care license.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021.<br><br>R4's diagnoses included traumatic brain injury (TBI), Lewy Body Dementia, high blood pressure and osteoarthritis of knees.<br><br>R4's Activity Plan dated May 23, 2022, identified R4's current activity preferences however the activity plan did not include the following:<br>- emotional and social needs and patterns;<br>- adaptations necessary for the resident to participate; and<br>- identification of activities for behavioral interventions.<br><br>On May 24, 2022, at 1:29 p.m., registered nurse (RN)-G verified R4's activity plan was not complete and added "the system is not pulling things together," and the issue affected all resident plans.<br><br>The licensee's Activities policy dated September 1, 2020, indicated residents are offered appropriate planned and spontaneous activities, to include: | 02170 | | |

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| 02170 | Continued From page 35<br>-activity program supports the service plan as applicable. The service plan helps to identify and guide activities planning for each individual resident;<br>-activity program reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values experiences, needs, interest, abilities, and skills;<br>-residents are free to choose their levels of participation in all activities offered; and<br>-a written schedule of activities is developed, publicly posted in the common area, and accessible to residents and their legal representatives.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02170 | | |
| 02310 SS=G | 144G.91 Subd. 4 Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of three residents (R1) with side rails.<br>In addition, based on observation, interview, and record review, the licensee failed to provide care | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 36<br>and services according to acceptable health care standards, medical or nursing standards for one of three residents (R2) who utilized a heating pad.<br><br>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 a limited number of staff are involved or the situation has occurred only occasionally).<br><br>This practice resulted in an immediate correction order on May 24, 2022, related to resident identifier, R1.<br><br>The findings include:<br><br>Side Rails<br>On May 24, 2022, at approximately 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. The surveyor observed a u-shaped grab-bar device attached to R1's bed. When the surveyor grabbed the u-bar there was some back-and-forth movement. The bottom of the u-bar fit between the mattress and box spring and did not easily move out or back in. During the observation, R1 stated she used the u-bar to help get up in the night to use the bathroom. R1 stated the facility went over risks and benefits of side-rail usage with her during her admission but in a generic manner, not as it pertained to R1's specific device as it was not in place yet.<br><br>R1's current service plan dated May 24, 2022, indicated R1 was admitted to the licensee on May 2, 2022, and received the following services: | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 37 | 02310 | | |

medication management, C-PAP (continuous positive airway pressure) cleaning and vitals. R1's diagnoses included hypertension, obstructive sleep apnea and arthritis.

R1's bed rail assessment dated May 24, 2022, noted director of nursing (DON)-B reviewed information regarding the risks vs. benefits of the side rail with R1 and provided R1with the FDA "A Guide to Bed Safety" handout. The assessment did not address whether or not the device was installed per manufacturer's installation instructions. The assessment noted a risk for the rails as entrapment or a potential restraint if the resident were unable to transfer properly. The assessment did not address any resident-centered interventions planned to mitigate the recognized safety risk. The assessment indicated R1 used a pendant system.

On May 24, 2022, at 12:10 p.m., DON-B stated she assessed R1 and the u-bar today after R1 mentioned to her that the surveyor asked R1 about it. DON-B stated the u-bar had an opening that measured eight (8) inches and she watched R1 use the u-bar to get out of bed and spoke with R1's husband. DON-B stated the eight-inch opening of the u-bar was a safety risk for R1. In response, DON-B stated she increased the safety checks today for R1 from every two hours to hourly. DON-B stated R1's family installed the u-bar after R1's admission without the facility's knowledge. DON-B stated R1's husband told her he was planning to order an insert to decrease the size of the opening.

On May 24, 2022, at approximately, 2:30 p.m., the surveyor requested to view the manufacturer's installation instructions for the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 38<br><br>resident's u-bar device, Freedom Grip model #501 from Mobility Transfer Systems. As of 5:12 p.m., the licensee had not produced the instructions.<br><br>The licensee's Siderails policy dated March 18, 2020, indicated [the facility] limits the use of medical devices to those that are considered "safe", based on current standards of practice, manufacturer guidelines and FDA guidelines. When [the facility] is aware a home care client is utilizing siderails (a medical device) on a bed, [the facility] 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.<br><br>The 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."<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>Assessment for Device<br>R2's record lacked evidence that the registered | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | 05/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS OF CROSSLAKE | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 39<br>nurse (RN) completed an assessment/reassessment prior to use of a heating pad.<br><br>On May 24, 2022, at 7:42 a.m., the surveyor observed unlicensed personnel (ULP)-D using a finger prick method to draw blood to check R2's blood glucose and administer R2's morning medications. R2 was sitting on her bed with a coverless heating pad laying between her abdomen and upper leg on the right side of her body. R2 commented the heat from the pad felt good where it was placed.<br><br>R2's assessment dated January 18, 2022, did not include an assessment for the use of a heating pad.<br><br>On May 24, 2022, at 1:30 p.m., RN-B confirmed R2's assessment dated May 24, 2022, did not reflect the resident's individual needs for use of a heating pad. RN-B commented "I asked her if it shut off after 20 minutes like mine did at home?"<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02310 | | |

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *05/23/22*
Time: 12:30:00
Report: 1017221093

# Food and Beverage Establishment Inspection Report



**Location:**
Golden Horizons Of Crosslake
13631 E Shore Rd
Crosslake, MN56442
Crow Wing County, 18

**Establishment Info:**
ID #: 0038875
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2186926650
ID #:

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

The following orders were issued during this inspection.

**5-200B Plumbing: cross connections**

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

PREVIOUSLY ORDERED 4.28.2021- REMOVE THE WYE VALVE FROM MOP SINK FAUCET PROVIDE A "SIDEKICK" DEVICE OR DISCONNECT HOSE TO CHEMICAL DISPENSER FROM FAUCET AFTER EACH USE. SAME 5.23.22.

*Comply By: 05/23/22*

**4-600 Cleaning Equipment and Utensils**

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

ICE MACHINE WAS OBSERVED WITH MOLD ON INSIDE FLANGE. CLEAN ICE MACHINE TO BE FREE OF MOLD. SHEILA SCHYMA STATED THAT THIS WAS ON THE DAILY CLEANING LIST FOR 5.23.22.

*Comply By: 05/30/22*

**Surface and Equipment Sanitizers**

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

# Food and Beverage Establishment Inspection Report



Quaternary Ammonia: = 200 PPM at  Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit  - Location: HASH BROWNS LOCATED IN 2 DOOR UPRIGHT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 207 Degrees Fahrenheit  - Location: MEAT LOAF LOCATED IN WARM HOLD
Violation Issued: No

Process/Item: Hot Holding
Temperature: 154 Degrees Fahrenheit  - Location: MASHED POTATOES LOCATED IN WARM HOLD
Violation Issued: No

Process/Item: Hot Holding
Temperature: 187 Degrees Fahrenheit  - Location: GRAVEY LOCATED IN WARM HOLD
Violation Issued: No

Process/Item: Hot Holding
Temperature: 166 Degrees Fahrenheit  - Location: BROCCOLI LOCATED IN WARM HOLD
Violation Issued: No

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

DISCUSSION;

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE SICKNESS LOG.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017221093 of 05/23/22.

Certified Food Protection Manager: SHELIA SCHYMA

Certification Number: 105304 Expires: 02/10/24

Signed: _____ Signed: _____

Establishment Representative

INSPECTOR ID # 1017

651-201-4500
health.foodlodging@state.mn.us

Report #: 1017221093

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**
**Food, Pools & Lodging Services**
**P.O. BOX 64975**
**ST. PAUL, MN 55164-0975**

| | | | |
|---|---|---|---|
| **No. of RF/PHI Categories Out** | 1 | **Date** | 05/23/22 |
| **No. of Repeat RF/PHI Categories Out** | 0 | **Time In** | 12:30:00 |
| **Legal Authority MN Rules Chapter 4626** | | **Time Out** | |

| | **Address** | **City/State** | **Zip Code** | **Telephone** |
|---|---|---|---|---|
| Golden Horizons Of Crosslake | 13631 E Shore Rd | Crosslake, MN | 56442 | 2186926650 |

| **License/Permit #** | **Permit Holder** | **Purpose of Inspection** | **Est Type** | **Risk Category** |
|---|---|---|---|---|
| 0038875 | | Full | | |

## 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 |
|---|---|---|---|---|
| | **Supervision** | | | |
| 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 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | X | 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:** 05/24/22

Inspector (Signature)