STATE LICENSING COMPLIANCE REPORT

Report #: HL335726536C **Date Concluded:** February 26, 2024

Name, Address, and County of Facility Investigated:
Golden Pond Mounds View
7245 Hidden Hollow Court
Mounds View, MN 55112
Ramsey County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Barbara Axness, RN
Special Investigator

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33572	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND MOUNDS VIEW	7245 HIDDEN HOLLOW COURT MOUNDS VIEW, MN 55112

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL335726536C On February 21, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL335726536C, tag identification 0495, 1070.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week	0 495		

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0 495	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a registered nurse (RN) available for staff to consult 24 hours a day, seven days per week due to the clinical nurse supervisor (CNS) employed also having full time employment obligations at a hospital. The back up RN was out of the country and not available to take calls or immediately respond to communication. This had the potential to affect all residents and staff of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 21, 2024, at 11:15 a.m., the investigator called licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B to initiate a complaint investigation. LALD/CNS-B's phone was off and the call went straight to voicemail. The investigator left a message requesting a call back. On February 21, 2024, at 11:17 a.m., the investigator called chief executive officer/registered nurse (CEO/RN)-A to initiate a complaint investigation. CEO/RN-A's phone was off and the call went straight to voicemail. The investigator left a message requesting a call	0 495		

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0 495	Continued From page 2 back. On February 21, 2024, at 11:20 a.m., the investigator sent an email to LALD/CNS-B and CEO/RN-A requesting a response and updated phone numbers to contact someone. On February 21, 2024, at 2:25 p.m., the investigator called LALD/CNS-B to initiate a complaint investigation. LALD/CNS-B's phone was on and rang through to voicemail. The investigator left a message requesting a call back. On February 21, 2024, at 2:27 p.m., the investigator called CEO/RN-A to initiate a complaint investigation. CEO/RN-A's phone was off and the call went straight to voicemail. The investigator left a message requesting a call back. On February 21, 2024, at 2:30 p.m., the investigator called house manager (HM)-C to initiate a complaint investigation. The call went to voicemail. The investigator left a message requesting a call back. On February 21, 2024, at 4:18 p.m., LALD/CNS-B replied to the investigator's email and indicated CEO/RN-A was traveling but "should be able to receive voice mail/calls once she arrived to her destination." and when calling LALD/CNS-B's number to "please leave a voice message if I don't pick up as I work nights at the hospital." The investigator replied to the email asking who would be the RN on call while she was working. On February 21, 2024, at 5:56 p.m., LALD/CNS-B replied, "It is usually [CEO/RN-A] Staff, depending on the urgency of the situation, follows a certain	0 495		

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0 495	Continued From page 3 protocol on what to do if they cannot reach me and if they still cannot reach [CEO/RN-A] . If I am working nights in the hospital, I also checked if I have any message from [the facility], when I come home in the morning before I rest/ sleep, I check as well for anything that should be addressed right away since I usually able to check again and return/ respond to messages and calls that I need to follow up on around 1-2 pm as I get ready to pick up my kids from school. So yeah, basically I am almost 24H on call with [CEO/RN-A] as a back up as she is also a Nurse. On February 21, 2024, at 8:08 p.m., LALD/CNS-B stated HM-C had not informed her the investigator had left a message regarding the complaint investigation. On February 22, 2024, at 2:55 a.m., CEO/RN-A emailed that she was currently in Korea and would be enroute to the Philippines and could "check my emails again in a few hours." On February 23, 2024, at 1:20 p.m., LALD/CNS-B stated CEO/RN-A would be out of the country through March 21, 2024. LALD/CNS-B stated the plan for a back up RN while she was at her other job or sleeping was that staff would call 911 if it was an emergency medical issue. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	0 495		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the	01070		

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01070	Continued From page 4 facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. The resident remained in the hospital for 22 days, despite being medically cleared for discharge while he waited for other placement. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included traumatic brain injury (TBI), paraplegia, and chronic pain. R1's service plan dated November 11, 2021, indicated the resident received assistance with emotional support, dressing, grooming, and medication management. R1's July 31, 2023, assessment indicated the resident had a history of property destruction and	01070		

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01070	Continued From page 5 his behaviors began to be aggressive after spending a few weeks in jail. The assessment indicated the resident had until August 31, 2023 to find a new place as he had been given a "60 day service termination/eviction notice by CEO [chief executive officer]." R1's progress notes indicated on June 26, 2023, a 911 crisis team came to the facility at 2:00 p.m. to assess and discuss R1's increasing behaviors. Staff were instructed to call 911 if the resident became aggressive and "a meeting with the case manager was set up to discuss eviction notice." Two hours later, the resident's case manager arrived at the facility to "discuss the termination and eviction notice with [R1]. [R1] agreed to leave and asked his case manager to find him another home..." R1's record contained a Resident Termination and Eviction Notice dated July 1, 2023, indicated a 60 day notice for violation of Resident Care Agreement was issued. The termination of the contract was effective August 31, 2023. Reasons for the termination listed six individual points including "the health or safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, refusal to maintain the cleanliness of the premise, verbal aggression towards staff...physical aggression and property destruction...non compliance with proper nursing procedures for safety and infection control, and threatening the staff to shoot them, using a knife knowing it is not allowed, and using demeaning words that intimidate the staff and the other residents causes increased anxiety and feeling unsafe to be in close contact with you." The notice was signed by facility staff on June 26, 2023.	01070		

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01070	Continued From page 6 A police report dated October 5, 2023, indicated officers were called to the facility for a person in crisis. The resident became "verbally hostile" towards the officers. The police report indicated other staff and residents were scared of the resident and afraid he was going to assault them so the officer put the resident on a hold and brought him to the hospital for further evaluation. Hospital records indicated the resident admitted to the hospital on October 5, 2023, after an "episode of aggression at group home." The resident spent 22 days in the hospital awaiting alternative placement "as his former placement evicted him." Additional notes from the hospitalization indicated the resident had "difficult to manage behaviors which is part of why his ALF [assisted living facility] evicted him which led to this hospitalization." On February 22, 2024, at 2:55 a.m., chief executive officer/registered nurse (CEO/RN)-A emailed, "If this is regarding [R1], his behaviors were so dangerous that he shouldn't be placed back to any home setting until he became stable again. I am glad you are investigating this case as it may help us providers protect our other residents and staff from having to experience such a horrifying experience. I am hoping it will help make some changes in the MN Statutes Rules for discharge. There should be an exemption to the rule." On February 23, 2024, at 12:40 p.m., house manager (HM)-C stated he was not sure if the appropriate termination steps were taken as CEO/RN-A handled the process. HM-C stated R1 had threatened to burn the house down and threatened other staff and residents so the facility would not take him back after he was sent to the	01070		

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01070	Continued From page 7 hospital. On February 23, 2024, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated a termination notice was issued on July 1, 2023, due to the resident's increasing behaviors. LALD/CNS-B stated the resident was sent to the hospital after an incident and the direction she received from CEO/RN-A was that the resident could not return from the hospital. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		