Electronically Delivered

February 10, 2025

Licensee
Golden Pond BP
10251 Yates Drive
Brooklyn Park, MN 55443

RE: Project Number(s) SL36447016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

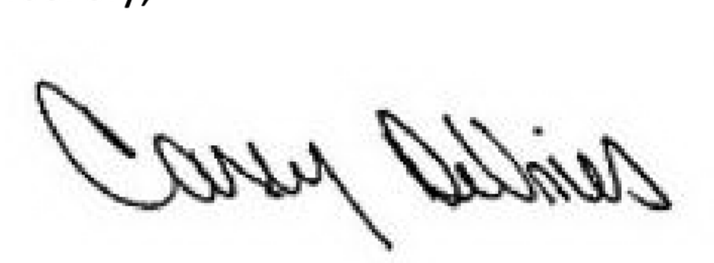
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36447	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND BP	10251 YATES DRIVE BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36447016-0 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). 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	0 660		

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0 660	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C started employment with licensee on July 6, 2024. ULP-C's record included a TB baseline screening (history and symptom screen) completed on October 3, 2024, and a chest x-ray with a negative result completed on November 2, 2023. ULP-C's record lacked a positive TB test to correlate with the chest x-ray. On December 17, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee used chest x-rays as a standalone document for most of the employees especially those who had received a BCG vaccination (Bacille Calmette-Guérin (BCG) is a vaccine for tuberculosis). The Minnesota Department of Health's Regulations for Tuberculosis Control in Minnesota Health Care Settings dated June 30, 2023, indicated employers should disregard a health care worker's history of BCG vaccination when administering and interpreting a TST. The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions (FAQs) dated June 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step	0 660		

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0 660	Continued From page 5 tuberculin skin test (TST) or single TB blood test. The FAQs also indicated a chest x-ray alone is not acceptable documentation, and that documentation must include: - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test; and - a chest x-ray (CXR) with provider evaluation after that date. The licensee's TB Prevention and Control policy dated October 2021, indicated upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. Also indicated a chest x-ray will be accepted if the staff member has a negative chest x-ray and the positive Mantoux test that required the chest x-ray. The chest x-ray must be 90-days prior to or any time after the positive Mantoux test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 6 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all staff, visitors, and residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 680		

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0 680	Continued From page 7 a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - maintain and annual EP updates; - EP program patient population; - process for EP collaboration; - subsistence needs for staff and residents including emergency lighting; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; On December 17, 2024, at 2:15 p.m., the clinical nurse supervisor (CNS)-A stated they had reviewed the EPP with licensed assisted living director (LALD)-D however, it was not fully updated. LALD-D stated they were happy with the progress they had made with their EPP and that they would update the EPP to reflect requirements. The licensee's Emergency Management Policy dated August 1, 2021, indicated [licensee] will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 790	Continued From page 8	0 790		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide and maintain adequately rated portable fire extinguishers as required for the facility. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 17, 2024, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. The following was observed: The mounted fire extinguishers located in the	0 790		

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0 790	Continued From page 9 kitchen and adjacent to the bedroom hallway were 1-A:10-BC rated. All fire extinguishers in the facility should meet the minimum required rating per statute. The fire extinguisher on the main level located adjacent to the laundry room and the lower-level fire extinguisher were not mounted in accordance with Minnesota Fire Code. MN Fire Code, chapter 7511 indicates fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. On December 17, 2024, at 1:30 p.m., CNS-A stated they would get the fire extinguishers properly mounted and remove the fire extinguishers that were too small. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 10 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 810		

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0 810	Continued From page 11 On December 17, 2024, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety/ Evacuation Emergency Procedures", undated, and "9.07 Fire Safety, Evacuation Plan, Fire Drills", dated August 1, 2021, failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. Policy included information for resident identified in policy as Resident 1, but policy did not include any information for the other two residents living at the facility. On December 17, 2024, at 1:00 p.m., CNS-A stated they do assessments for residents on intake and develop their specialized evacuation plan from that assessment. CNS-A stated that they had not finished developing the evacuation plans for two of the residents currently living in the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS-A lacked	0 810		

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0 810	Continued From page 12 documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On December 17, 2024, at 1:00 p.m., CNS-A stated they completed the resident training, but had no system for documenting it. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded prescription was obtained for one of two residents (R2). 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: R2 was admitted to the licensee and began receiving assisted living services on March 11,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36447	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND BP	10251 YATES DRIVE BROOKLYN PARK, MN 55443

(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
01820	Continued From page 13 2024. R2's diagnoses included paranoid schizophrenia and traumatic brain injury (TBI). R2's Service Plan (Waiver) - Addendum to Contract dated April 3, 2024, indicated R2 received medication administration services. On December 17, 2024, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. R2's medication administration record (MAR) dated December 1, 2024, through December 17, 2024, indicated R2 was taking the following medications: - baclofen tablet 20 milligrams (mg) take one tablet three times daily by mouth; - docusate capsule 100 mg take one capsule by mouth once daily; - nicotine Td dis 21mg/24h apply one patch to clean, dry, hairless skin once daily remove old patch before applying new patch; - hydrochlorothiazide capsule 37.5-25 take one capsule by mouth once daily; - vitamin D3 25mcg (1000iu) capsule take one capsule by mouth once daily; - banophen 25 mg tablets take two tablets (50mg) by mouth at bedtime; - olanzapine tablet 25 mg dissolve one tablet by mouth at bedtime; - tizanidine tablet 4 mg take one tablet by mouth three times daily as needed for muscle spasms; - fluphenazine tablet 2.5 mg take one tablet by mouth once daily as needed for agitation; - albuterol 90 microgram (mcg) hfa inhaler inhale two puffs into the lungs every four hours as needed for shortness of breath or wheezing as needed; and	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36447	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 14 - bisacodyl tablet 5 mg take one tablet by mouth once daily as needed for constipation. On December 17, 2024, clinical nurse supervisor (CNS)-A stated the licensee had electronically signed pharmacy prescriptions for all of R2's medications and that they would provide them. The surveyor made muiltiple requests for the remaining prescriptions however, by the survey exit, they had only provided the following: - fluphenazine tablet 2.5 mg take one tablet by mouth once daily as needed for agitation; - tizanidine tablet 4 mg take one tablet by mouth three times daily as needed for muscle spasms; and - bisacodyl tablet 5 mg take one tablet by mouth once daily as needed for constipation. The licensee's Medication Orders policy dated July 21, 2022, indicated the licensee will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of rights and in the Health Insurance Portability and Accountability Act. The policy also indicated when a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36447	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND BP	10251 YATES DRIVE BROOKLYN PARK, MN 55443

(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
01890	Continued From page 15 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of two residents (R3). In addition, the licensee failed to ensure all medications were labeled with the resident's identifying information. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee and began receiving assisted living services on October 10, 2022. R3's Service Plan (Waiver) - Addendum to Contract dated December 13, 2024, indicated R3 received medication administration services. On December 17, 2024, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R3. On December 17, 2024, at 11:00 a.m., the surveyor observed R3's medication box and the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36447	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 16 following medications were expired: - two packets of baclofen tablet 10 milligram (mg) take one half tablet by mouth every eight hours as needed for pain both expired on May 2, 2024; - senna-time tablet 8.6 mg take two tablets by mouth once daily as needed for constipation expired on July 27, 2023, and September 4, 2023. The following unlabeled medications were also observed in the medication closet: - unlabeled pharbetol acetaminophen 325 mg; - unlabeled cough syrup dextromethorphan usp 20 mg; and - earwax removal drops carbamide peroxide 6.5%. On December 17, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated they had missed the expired medications as they were hidden in a folder. CNS-A also stated all medications were supposed to be labeled at least with resident initials if they were an over-the-counter medication. The licensee's Medication Disposal policy dated August 1, 2021, indicated [licensee] will dispose any medication, as needed, in a proper way including following the guidelines of the Minnesota Board of Pharmacy. The licensee did not have a policy that addressed labeling resident medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *12/16/24*
Time: 10:45:00
Report: 1051241194

Food and Beverage Establishment Inspection Report

Location:
Golden Pond Bp
10251 Yates Drive
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038499
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632085247
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.

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION, THERE IS NO CERTIFIED FOOD PROTECTION MANAGER.

Comply By: 12/23/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, BENARD NYANGENA.

DISCUSSED THE FOLLOWING WITH THE NURSE, ANNALIZA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE

THE KITCHEN HAS A NSF 184 DISHWASHER, LAMINATE CABINETS, EPOXY COUNTERTOPS WITH HOLLOW BASES, & AN ORANGE-PEEL TEXTURE CEILING.

Type: Full
Date: *12/16/24*
Time: 10:45:00
Report: 1051241194
Golden Pond Bp

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241194 of 12/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Annaliza
Nurse

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us