Electronically Delivered

April 17, 2026

Licensee
Golden Light Assisted Living L.L.C.
600 Landau Drive
Woodbury, MN 55125

RE: Project Number SL35224016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 2026, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

(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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35224016-0 On March 30, 2026, through April 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving 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.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two unlicensed personnel (ULP-B, ULP-D). 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).	0 650		

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0 650	Continued From page 2 The findings include: During the entrance conference on March 30, 2026, at 10:25 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they were aware of the required contents of the employee records. The licensee's March 2026, HHA (Home Health Aide) Schedule indicated ULP-B was scheduled to work 19 shifts for the month, and ULP-D was scheduled to work double shifts (3:00 p.m. through 7:00 a.m.) on March 7, 8, 21, and 22, 2026. ULP-B ULP-B was hired on February 9, 2024, to provide direct care services to residents. On March 30, 2026, at 2:20 p.m., during ULP-B's record review, the surveyor observed two forms titled Unlicensed Personnel Competency Evaluation for ULP-B with the following information: -the first evaluation was undated, indicated ULP-B was competent on basic and comprehensive skills including medication and treatments as delegated. Each competency had LALD/RN-A's initials but was not signed by either LALD/RN-A or ULP-B; -the second evaluation was dated March 30, 2024, which indicated ULP-B was competent on the same skills as listed on the other form but each skill was not initialed by LALD/RN-A. At the bottom of the evaluation, it was signed by LALD/RN-A only. The surveyor asked LALD/RN-A which form was the competency evaluation and LALD/RN-A stated the form dated March 30, 2024, was	0 650		

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0 650	Continued From page 3 evidence of initial demonstrated competency. The surveyor then requested ULP-B's 30-day supervision by the RN, and LALD/RN-A provided the staff supervision summary indicated the first supervision completed on ULP-B was on March 10, 2024, checking a blood sugar. 30-day supervision by the RN is conducted within 30 days of performing delegated tasks. ULP-B's employee record lacked clear documentation of when training and competencies were completed and lacked documentation of medication routes that were demonstrated to the RN. During interview on March 31, 2026, at 3:30 p.m., LALD/RN-A stated she trained ULP-B on all medication routes but for return demonstration, she observed ULP-B perform medication routes that were used at that time. LALD/RN-A could not provide documentation on which routes where demonstrated to her. ULP-D ULP-D was hired on February 15, 2026, to provide direct care services to residents. ULP-D's employee record included a 30-day performance review dated March 18, 2026, which indicated ULP-D's performance was satisfactory and to continue working on the new hire training materials and online education, a positive tuberculosis (TB) blood test dated June 9, 2024, and job description dated December 27, 2025. ULP-D's employee file lacked records of orientation, infection control training, and competency evaluations. On March 31, 2026, at 2:30 p.m., LALD/RN-A	0 650		

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0 650	Continued From page 4 stated she had been working with ULP-D on each shift and completing training along the way. LALD/RN-A could not provide any training records including an online training transcript to show what had been completed so far. The surveyor stated the staff schedule showed ULP-D was scheduled to work double shifts two weeks that month and asked if LALD/RN-A was working those same shifts. LALD/RN-A responded by nodding her head yes and explained ULP-D required more training. During a phone interview on April 1, 2026, at 9:30 a.m., ULP-D confirmed they were employed with the licensee and began working middle of February. ULP-D stated they worked PM and overnight shifts on Saturdays and Sundays. ULP-D stated LALD/RN-A was working with them on the PM shift, but LALD/RN-A would leave at 11 p.m. and then return at 6:00 a.m., leaving ULP-D by themselves to complete the required overnight tasks. ULP-D stated they were still in training (mentioned online training numerous times) but was trained on medication administration, transfers, oxygen therapy, bathing as examples. The licensee's 4.05 Employee Records policy dated December 13, 2025, noted records of all training and in-service education required, completed orientation, annual training, and competency testing as required would be kept in the personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 5	0 660		
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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a TB history and symptom screening for upon hire for two of two unlicensed personnel (ULP-B, ULP-D). 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).	0 660		

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0 660	Continued From page 6 The findings include: The licensee's undated, Facility TB Risk Assessment indicated the facility was at a low risk for TB transmission. The assessment indicated licensed assisted living director and registered nurse (LALD/RN)-A was responsible for maintaining TB screening records and the person responsible for TB infection control in the licensee's health care setting. ULP-B ULP-B was hired February 9, 2024, to provide direct care for the residents. ULP-B's record included documentation of a negative one-step tuberculin skin test (TST), dated November 20, 2023, and an incomplete assessment for TB history (all questions were not answered and not signed by the person completing the assessment). ULP-B's record lacked documentation that a second TST was completed 7-21 days later, as required. On March 30, 2026, at 2:20 p.m. during ULP-B's record review, the surveyor asked LALD/RN-A if a second TST was available. LALD/RN-A was not aware a 2nd TST was required. On March 30, 2026, at 3:04 p.m., LALD/RN-A provided ULP-B's negative chest x-ray report completed on March 26, 2026. The report was completed for another job unrelated to this licensee. ULP-D ULP-D was hired February 15, 2026, to provide	0 660		

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0 660	Continued From page 7 direct care for the residents. ULP-D's record included documentation of a positive TB serum test dated June 9, 2024, but lacked documentation of follow up physical examination and chest x-ray to rule out active TB disease. On March 30, 2026, at 3:04 p.m., LALD/RN-A stated they did not have documentation of a completed chest x-ray. LALD/RN-A thought the TB serum test was negative at the time because of the reference interval. A few minutes later, LALD/RN-A explained she contacted ULP-D and said ULP-D would send over a chest x-ray report. On March 31, 2026, at 9:38 a.m., human resources (HR)-C provided ULP-D's chest x-ray dated July 19, 2024, indicating there was no evidence of active TB disease. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2025, indicated new staff would have a TB serum test or two-step TST conducted with results documented on the results documented on the baseline TB screening tool for health care workers. No staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first TST are read and documented or a negative TB serum test is received and documented. Staff TB screening results would be kept in each employee medical file. The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening	0 660		

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0 660	Continued From page 8 including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. The MDH Regulations for TB Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 or unusual resident needs for movement or	0 810		

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0 810	Continued From page 9 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 10 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 11 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R1). 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:	01060		

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GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

(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
01060	Continued From page 12 R1 was admitted to the licensee on July 18, 2025, for assisted living services. R1's diagnoses included schizoaffective disorder, anxiety disorder, bipolar disorder, and manic depression. R1's Master Care Plan last updated on August 8, 2025, indicated R1 received assistance with behavior management, laundry, housekeeping, and medication management. R1's resident note dated August 25, 2025, by licensed assisted living director/registered nurse (LALD/RN)-A indicated she received a call from another resident feeling scared due to R1's erratic behavior. The police then restrained R1 and took R1 to [hospital name]. R1's resident note dated August 29, 2025, indicated LALD/RN-A received an email from the mental health worker indicating R1 was being committed and will mostly likely remain in the hospital for 2-3 weeks. R1's record lacked an emergency relocation written notice and evidence the ombudsman was notified R1 had been relocated and had not returned to the facility within for days. On April 1, 2026, at 11:53 a.m., LALD/RN-A explained when a resident is sent to the hospital, they send the resident's medication list. LALD/RN-A also explained R1 did not want the licensee to be updated on their status, so the licensee was unable to make contact. When asked if the ombudsman had been contacted, LALD/RN-A did not know at the moment but would look up the ombudsman website or look at the licensee's electronic health record (Residex)	01060		

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	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

(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
01060	Continued From page 13 for further information. LALD/RN-A was unaware of the requirement. The licensee's 1.23 Emergency Relocation policy dated August 1, 2025, indicated in the event of an emergency relocation, licensee would provide a written notice that contained the required information. The notice would be delivered as soon as practicable to the resident, legal representative, designated representative, and case manager if applicable. If the resident has not returned to the facility within four (4) days, OOLTC would be notified as well. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

(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
01640	Continued From page 14 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to revise and obtain a resident or resident representative's signature documenting a change of services to be provided for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Throughout the survey from March 30, 2026, to March 31, 2026, the surveyor observed staff provide R3 with one assist with transfers using a gait belt and two-wheeled walker. R3 was admitted to licensee on March 11, 2021. R3's Service Plan - Modification signed February 20, 2023, indicated R3 received assistance with ambulation, bathing, medication and treatment management, behavior management, safety checks, toileting, laundry once a week, and transfer assistance.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

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01640	Continued From page 15 R3's resident note dated December 26, 2025, indicated R3 had right ankle surgery and it was successful. R3's resident note dated December 30, 2025, indicated R3 returned to the facility with their right ankle splinted and covered with ace wrap. R3's Service Recap Summary-Month dated March 2026, included documentation staff completed the following services: -monitor right ankle incision twice daily; -encourage resident to use bed rail for repositioning and transfers once daily; -elevate right foot three times daily; -staff to remove wheelchair or walker when not in use to help prevent self transfers three times daily; and -resident has a history of calling 911 for extra fluids-staff to call the registered nurse (RN) each time resident calls 911 three times daily. R3's medical record lacked an updated signed service plan to include the above revisions. On March 31, 2026, at 1:22 p.m., licensed assisted living director/RN (LALD/RN)-A stated they did not have a updated signed service agreement to include the changed/added services. The licensee's 6.08 Service Plan policy dated August 1, 2025, indicated the service plan and any revisions shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services provided. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35224	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENLIGHTASSISTEDLIVING LLC	600 LANDAU DRIVE WOODBURY, MN 55125

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01650	Continued From page 17 plan included the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Throughout the survey from March 30, 2026, to March 31, 2026, the surveyor observed staff provide R3 with assist of one to with transfers using a gait belt and two-wheeled walker. R3 was admitted to licensee on March 11, 2021. R3's Service Recap Summary - Month dated March 2026, indicated R3 had received services for medication and treatment management, bathing assistance, transfer assistance, behavior management, and dressing assistance. R3's Service Plan - Modification signed February 20, 2023, lacked the following required content: 1. the schedule and methods of monitoring assessments of the resident; 2. the schedule and methods of monitoring staff providing services; and 3. a contingency plan that includes: a. the action to be taken if the scheduled service cannot be provided; b. information and a method to contact the facility; c. the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 18 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and d. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On March 31, 2026, at 1:22 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the service plan dated February 20, 2023, was the most current service plan, and it did not include the above required content. The licensee's 6.08 Service Plan policy dated August 1, 2025, indicated the service plan would include: 1. A schedule and methods of monitoring assessments of the resident 2. A schedule and methods of monitoring staff providing services 3. A contingency plan that includes: a. the action to be taken if the scheduled service cannot be provided; b. information and a method to contact the facility; c. the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and d. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R3) with hospital-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During facility tour on March 30, 2026, at 11:30 a.m., with licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor observed R3's unoccupied hospital bed	02310		

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	35224	A. BUILDING: _____ B. WING _____	04/02/2026

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02310	Continued From page 20 with bilateral upper 1/2 bed rails in the raised position. The bed rails were secured to the bed. LALD-RN-A stated she completed bed rail assessments and measurements every 90-days or with a change in condition. R3 was admitted on March 11, 2021, with diagnoses including schizophrenia, closed fracture of right ankle, obstructive sleep apnea (sleep disorder due to interruptions in breathing), paralytic ileus (paralyzed muscle contractions within intestines causing constipation, bloating, and gas), and chronic lower extremity edema (swelling). R3's Service Recap Summary-Month dated March 2026, included bed rails and staff were to encourage R3 to use bed rail for positioning and for getting in and out of bed. R3's Assessment by Date completed by LALD/RN-A on January 12, 2026, indicated R3 had a bed rail for positioning in bed. The assessment did not include measurements for zones 1, 2, 3, and 4; it only included "yes" or "not applicable." The assessment also lacked documentation of physical inspection of bed rail, stability, and correct installation. During exit conference on April 2, 2026, at 12:25 p.m., the surveyor instructed LALD/RN-A on how to access information on bed rail assessment requirements on the Minnesota Department of Health (MDH) website. She explained she was unaware actual measurements were required to be documented. The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated the licensee would assess the use, educate the resident, and verify	02310		

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02310	Continued From page 21 the bed rails in use are of safe design and utilized consistent with the manufacturer's direction. The policy also indicated the bed rail design should be consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. That meant bed rail zones 1-3 must not exceed 4.75." The policy did not include zone 4, or how the information should be documented. The Food and Drug Administration's (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated March 10, 2006, indicated zones 1-3 should be less than 4 3/4 inches and zone 4 should be less than 2 3/8 inches to prevent risks of entrapment. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) updated March 9, 2026, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for	02310		

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	35224	A. BUILDING: _____ B. WING _____	04/02/2026

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02310	Continued From page 22 areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GOLDEN LIGHT ASSISTED LIVING LLC
600 LANDAU DRIVE
Woodbury, MN 55125
Washington County
Parcel:

Phone:

License Info

License: HFID 35224

Risk:
License:
Expires on:
CFPM: Chisom C. Ozioko
CFPM #: CFPM-26888; Exp: 01/11/2028

Inspection Info

Report Number: F1005261096
Inspection Type: Full - Single
Date: 3/31/2026 Time: 10:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSING EVALUATOR ANNA BOHNEN.

OPERATOR SENT INSPECTOR A PICTURE OF A THERMOLABEL AFTER RUNNING IT THROUGH THE DISHWASHER, SHOWING IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1005261096 from 3/31/2026

CHISOM OZIOKO
PIC

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

GOLDEN LIGHT ASSISTED LIVING LLC
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1005261096
Inspection Type: Full
Date: 3/31/2026
Time: 10:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RAVIOLI**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Cold-Holding
Location: GARAGE REFRIGERATOR at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

GOLDEN LIGHT ASSISTED LIVING LLC
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1005261096
Inspection Type: Full
Date: 3/31/2026
Time: 10:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Greater Than 160 Degrees F.
Comment: BETWEEN 160 AND 170 DEGREES F, PER THERMOLABEL
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35224016-0	**Date:** April 1, 2026
Facility Name: GOLDENLIGHTASSISTEDLIVING LLC	
Facility Address: 600 LANDAU DR, WOODBURY, MN 55125	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested all staff training on the FSEP from the licensed assisted living director/registered nurse (LALD/RN)-A and human resource (HR)-C. LALD/RN-A and HR-C stated they were using fire drills as training along with a web-based training that did not include the licensee's site-specific evacuation plan.