Electronically Delivered

May 13, 2026

Licensee
Golden Pond WBL
4624 Stoddart Circle
Saint Paul, MN 55127

RE: Project Number(s) SL32589016

Dear Licensee:

On April 14, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 26, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 22, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 22, 2026, found not corrected at the time of the April 14, 2026, follow-up survey and/or subject to penalty assessment are as follows:

**0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $1,000.00**

The details of the violations noted at the time of this follow-up survey completed on April 14, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

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

Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

**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**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

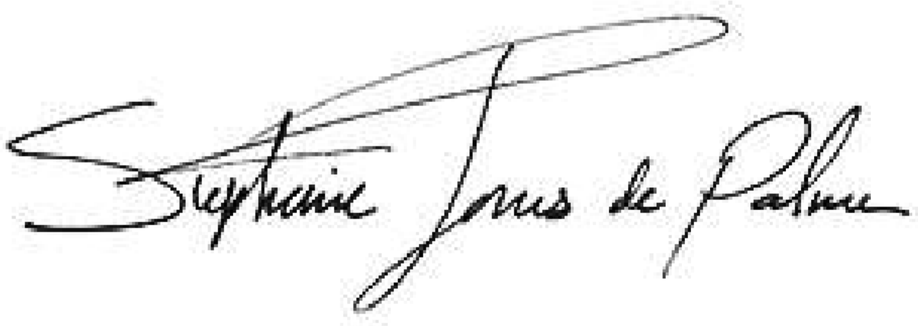
To submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,



Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 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 |
|---|---|---|---|
| | 32589 | A. BUILDING: _____ B. WING _____ | R 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN POND WBL | 4624 STODDART CIRCLE SAINT PAUL, MN 55127 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| {0 000} | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS<br><br>INITIAL COMMENTS<br>SL32589016-1<br><br>On April 13, 2026, through April 15, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on January 22, 2026. As a result of the follow-up survey, the following orders were reissued. | {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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| {0 510} SS=D | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and | {0 510} | | |

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| {0 510} | Continued From page 1<br>maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by: | {0 510} | | |
| {0 650} SS=D | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health | {0 650} | Not reviewed during this survey. | |

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| {0 650} | Continued From page 2<br>screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by: | {0 650} | Not reviewed during this survey. | |
| {0 680} SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced | {0 680} | | |

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| {0 680} | Continued From page 3<br>by: | {0 680} | Not reviewed during this survey. | |
| {0 800} SS=D | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by: | {0 800} | Not reviewed during this survey. | |
| {0 810} SS=I | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive | {0 810} | | |

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| {0 810} | Continued From page 4<br><br>training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April | {0 810} | | |

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| {0 810} | Continued From page 5<br>15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: None | {0 810} | | |
| {01290} SS=F | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by: | {01290} | Not reviewed during this survey. | |
| {01470} SS=E | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; | {01470} | | |

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| {01470} | Continued From page 6<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased | {01470} | | |

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| {01470} | Continued From page 7<br>incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by: | {01470} | Not reviewed during this survey. | |
| {01640} SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting 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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. | {01640} | | |

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| {01640} | Continued From page 8<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by: | {01640} | Not reviewed during this survey. | |
| {01760} SS=F | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by: | {01760} | Not reviewed during this survey. | |
| {01880} SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by: | {01880} | Not reviewed during this survey. | |

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| {01880} | Continued From page 9 | {01880} | Not reviewed during this survey. | |
| {01890} SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by: | {01890} | Not reviewed during this survey. | |
| {02320} SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by: | {02320} | Not reviewed during this survey. | |

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL32589016-1 | **Date:** April 15, 2026 |
| **Facility Name:** Golden Pond White Bear Lake | |
| **Facility Address:** 4624 Stoddart Circle, St Paul, MN 55127 | |

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 3; Widespread

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) and P.A.S.S (Pull, Aim, Squeeze, and Sweep) but the plan was designed for a building with life safety systems such as fire alarms and fire resistant construction. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems.*

   *The FSEP incorrectly stated that the facility is equipped with a fire alarm system. No fire alarm system was present in the facility. The FSEP had a section that discussed horizontal vs full evacuation. Horizontal evacuation is not an appropriate action to take in the event of a fire because the building is not separated into separate smoke compartments and is not equipped with life safety systems.*

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   *Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.*

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

   *Comments: On April 13, 2026, at 9:36 a.m. the surveyor emailed the licensee requesting staff training on the FSEP including any future dates for training. On April 14, 2026, at 1:44 a.m. clinical nurse supervisor*

*(CNS)-A responded to the surveyor's email requesting updated documentation. No staff training or future dates for training were included for review.*

4. 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. [Minn. Stat. 144G.45 subd.2]

   *Comments: On April 13, 2026, at 9:36 a.m. the surveyor emailed the licensee requesting resident training on the FSEP including any future dates for training. On April 14, 2026, at 1:44 a.m. (CNS)-A responded to the email requesting updated documentation. No resident training or future dates for training were provided for review.*

5. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   *Comments: On April 13, 2026, at 9:36 a.m. the surveyor emailed the licensee requesting documentation on emergency evacuation drills that had been conducted including any future dates. On April 14, 2026, at 1:44 a.m. (CNS)-A responded to the email requesting updated documentation. One additional fire drill dated April 2, 2026, was included. No additional emergency evacuation drills were provided for review. No plan for future dates of emergency evacuation drills was provided.*

Electronically Delivered

February 19, 2026

Licensee
Golden Pond WBL
4624 Stoddart Circle
Saint Paul, MN 55127

RE: Project Number(s) SL32589016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 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.

**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 . . ."

**IMPOSITION OF FINES**

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

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

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

pursuant to this survey:

**St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00**
**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**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**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32589 | A. BUILDING: _____ B. WING _____ | 01/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN POND WBL | 4624 STODDART CIRCLE SAINT PAUL, MN 55127 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL #SL32589016-0<br><br>On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents, all of whom were receiving services under the provider's Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3. | |
| 0 510 SS=D | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. | 0 510 | | |

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| 0 510 | Continued From page 1<br><br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff were appropriately gloved and performed adequate hand hygiene (HH) for one of three employees (unlicensed personnel (ULP)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D was hired January 23, 2024, to provide direct care services for the licensee's residents.<br><br>On January 21, 2026, during continuous observations from 6:30 a.m. to 7:00 a.m., ULP-D was observed assisting R1 with morning cares. | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>ULP-D washed their hands in a kitchen area, applied gloves, entered R1's room, and assisted R1 into a sitting position. ULP-D then assisted R1 with ambulating to a commode. ULP-D lowered R1's pants and removed a wet incontinent brief. ULP-D placed the soiled brief into a waste basket next to the commode and returned to R1's bed. ULP-D removed a disposable incontinent pad from the bed and placed it in the waste basket. Without removing gloves or performing HH, ULP-D removed the pillowcases from two pillows and placed the pillows on a lounge chair. ULP-D then, without removing gloves or performing HH, handled R1's blanket, checking to see if it was wet, folding it, and placed it on top of the pillows. ULP-D then, without removing gloves or performing HH, searched through R1's laundry basket, removed a bottom sheet and placed the sheet on the bed. ULP-D moved to R1's closet and without removing gloves or performing HH, gathered a clean pair of sweatpants and a sweatshirt, and brought them to R1. Without removing gloves or performing HH, ULP-D assisted R1 with dressing and directed R1 to move to the lounge chair. ULP-D, without removing gloves or performing HH, gathered the pillows and the bottom sheet from the chair, and made the bed. Without removing gloves or performing HH, ULP-D picked up a TV tray next to the bed and moved it out of the way. ULP-D retrieved another pillow from the closet and brought it to the bed. Without removing gloves or performing HH, ULP-D assisted R1 to the bed, assisted R1 into a lying position, and placed two blankets on top of R1. ULP-D then, without removing gloves or performing HH, gathered R1's soiled linen, opened the door, and exited R1 room. ULP-D brought the laundry to the laundry room, and placed the soiled laundry into a washing machine. Without removing gloves or | 0 510 | | |

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| 0 510 | Continued From page 3<br><br>performing HH, ULP-D retrieved laundry detergent from a closet, added the detergent to the washing machine and pushed the settings to start the wash cycle. ULP-D then removed their gloves and proceeded to the kitchen area to perform HH.<br><br>On January 21, 2026, at 7:00 a.m., ULP-D stated they had been trained by the registered nurse on handwashing technique. ULP-D stated hands should be washed for at least 20 seconds and gloves should be changed after tasks. ULP-D stated they forgot to change their gloves and that gloves were not available in R1's room. ULP-D stated they should have changed gloves between tasks.<br><br>On January 21, 2026, at 1:58 p.m., clinical nurse supervisor (CNS)-A stated the ULP should be performing HH between resident cares, anytime they come in contact with bodily fluids, and after removing gloves. CNS-A further stated she did not know why that was not done and she would retrain staff.<br><br>The licensee's 1.04 Infection Control policy, dated August 1, 2025, indicated staff would wash hands between tasks, and before and after applying and removing gloves. The policy further indicated gloves would be worn when anticipating contact with body fluids.<br><br>The CDC guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated healthcare personnel (HCP) should perform HH immediately before touching a patient (resident), after touching a patient or the patient's immediate environment and immediately, after contact with body fluids or | 0 510 | | |

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| 0 510 | Continued From page 4<br>contaminated surfaces, and after glove removal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 650 SS=D | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the employee record contained the required content, | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>including documentation of supervision done within 30 days after the individual began performing delegated tasks for one of three employees (unlicensed personnel (ULP)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D was hired on November 8, 2024, to provide direct care services for the licensee's residents.<br><br>On January 21, at 6:15 a.m., ULP-D stated he believed the registered nurse observed him assisting with medication administration within 30 days of providing services.<br><br>On January 21, at 6:30 a.m., ULP-D was observed assisting R1 with morning cares.<br><br>ULP-D's employee record lacked documentation of being supervised within 30 days of performing delegated tasks.<br><br>On January 21, at 1:34 p.m., clinical nurse supervisor (CNS)-A stated she had completed the 30 day supervision but had not documented it.<br><br>The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated the employee record would contain verification of completed | 0 650 | | |

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| 0 650 | Continued From page 6<br>orientation and annual training and competency testing as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by: | 0 680 | | |

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| 0 680 | Continued From page 7<br><br>Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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).<br><br>The findings include:<br><br>The licensee's EP plan, reviewed April 2024, lacked evidence of the following required content:<br>- documentation the EP plan was reviewed annually, and<br>- documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise.<br><br>On January 21, 2026, at 2:20 p.m., clinical nurse supervisor (CNS)-A stated they were not documenting drills accurately and they would change their process.<br><br>The licensee's 9.01 Emergency Preparedness-Appendix Z Compliance policy dated June 1, 2021, indicated the plan would include all the required elements of appendix Z | 0 680 | | |

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| 0 680 | Continued From page 8<br>and would be reviewed annually.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 800 SS=D | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). | 0 800 | | |

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| 0 800 | Continued From page 9<br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=I | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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. | 0 810 | | |

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| GOLDEN POND WBL | 4624 STODDART CIRCLE SAINT PAUL, MN 55127 |

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| 0 810 | Continued From page 10<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01290 SS=F | 144G.60 Subdivision 1 Background studies required | 01290 | | |

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| 01290 | Continued From page 11<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a Minnesota Department of Human Services (DHS) background study was submitted and received in affiliation with the assisted living license for one of six employees (unlicensed personnel (ULP)-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-C was hired August 28, 2023, and provided | 01290 | | |

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| 01290 | Continued From page 12<br>direct care services to the licensee's residents.<br><br>On January 20, 2026, at 2:10 p.m., the surveyor observed ULP-C assisting R3 with medication administration.<br><br>On January 20, 2026, at 3:20 p.m., the surveyor reviewed the licensee's Minnesota DHS NETStudy 2.0 background study roster. The NETStudy 2.0 roster indicated ULP-C became affiliated with the licensee's health facility identification (HFID), 32589 on January 20, 2026 (during the survey period).<br><br>On January 20, 2026, at 3:55 p.m., owner/licensed assisted living director (O/LALD)-A stated ULP-C was affiliated with the licensee's HFID 36647 and recently transferred to the current location. O/LALD-A stated when she realized ULP-C was not affiliated with HFID 32589 she made the required change.<br><br>On January 20, 2026, via email, at 7:20 p.m., O/LALD-A provided the surveyor with the licensee's Minnesota DHS NETStudy 2.0 background study roster for the sister-facility HFID 36647. The roster indicated ULP-C was affiliated with HFID 36647 on January 26, 2024.<br><br>The licensee's 4.02 Background Studies policy, dated December 2025, indicated "an employee may work at a different location within the [licensee] group of companies if an employee had a clearance/eligible result after the initial background study. An affiliation must be completed as soon as the employee accepts the employment in another location."<br><br>No further information was provided. | 01290 | | |

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| 01290 | Continued From page 13<br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 01470 SS=E | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), | 01470 | | |

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| 01470 | Continued From page 14<br><br>orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing assisted living services to residents for two of three employees (unlicensed personnel (ULP)-D, ULP-F).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a | 01470 | | |

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| 01470 | Continued From page 15<br><br>limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>ULP-D<br>ULP-D was hired January 23, 2024, to provide direct care services for the licensee's residents.<br><br>On January 21, 2026, at 6:30 a.m., the surveyor observed ULP-D assisting R1 with morning cares.<br><br>ULP-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services:<br>- an overview of the appropriate Assisted Living statutes 144G and rules;<br>- reporting maltreatment of vulnerable adults or minors;<br>- Assisted Living Bill of Rights;<br>- handling of resident complaints, reporting of complaints, where to report; and<br>-consumer advocacy services.<br><br>ULP-F<br>ULP-F was hired March 21, 2025, to provide direct care services for the licensee's residents.<br><br>A medication administration record (MAR) for R1, dated December 2025 and January 2026, indicated ULP-F assisted R1 with medication administration on December 5, 12, 19, and January 2, 16.<br><br>ULP-F's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services:<br>- handling emergencies and using emergency | 01470 | | |

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| 01470 | Continued From page 16<br><br>services;<br>- reporting maltreatment of vulnerable adults or minors;<br>- Assisted Living Bill of Rights;<br>- consumer advocacy services;<br>- review of types of Assisted Living services the employee will provide and provider's scope of license; and<br>- principles of person-centered planning/service delivery.<br><br>On January 21, 2026, at 1:23 p.m., clinical nurse supervisor (CNS)-A stated they thought staff had 90 days to complete orientation and did not realize it needed to be completed prior to providing services.<br><br>The licensee's Orientation and Annual Training Requirements policy, dated August 1, 2021, indicated staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting | 01640 | | |

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| 01640 | Continued From page 17<br><br>agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for one of three residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On January 21, 2026, at 7:36 a.m., the surveyor | 01640 | | |

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| 01640 | Continued From page 18<br><br>observed unlicensed personnel (ULP)-D assisting R1 with morning cares.<br><br>R1's service plan, dated December 18, 2025, indicated R1 received services including medication administration. The service plan was authenticated by R1 but lacked signature or other authentication by a facility representative documenting agreement on the services to be provided.<br><br>On January 21, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated that after the service plan was created by the registered nurse, the housing manager obtained the signatures.<br><br>On January 21, 2026, at 9:15 a.m., housing manager (HM)-E stated they "forgot" to sign R1's service plan.<br><br>The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plan and any revisions would include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must | 01760 | | |

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| 01760 | Continued From page 19<br><br>include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions and compliance with the resident's medication management plan for one of three residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>R1's diagnoses included Huntington's disease and asthma.<br><br>R1's service plan, dated December 18, 2025, indicated R1 received services including assistance with medication administration. | 01760 | | |

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| 01760 | Continued From page 20<br><br>R1's medication administration record (MAR) dated January 2026, indicated R1 received Symbicort inhaler (a combination drug of budesonide 80 micrograms (mcg) and formoterol fumarate 4.5 mcg, used to treat asthma) at 8:30 a.m., daily.<br><br>R1's record included a comprehensive nursing assessment dated December 9, 2025. The medication management category of the assessment indicated R1 did not self-administer his own medications.<br><br>On January 21, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B assisting R1 with medication administration. ULP-B prepared the medications and left them on a TV tray for R1, then exited the area to assist other residents.<br><br>On January 21, 2026, at 7:55 a.m., the surveyor observed R1 independently taking his morning medications. R1 shook the inhaler, took the cap off the mouthpiece and administered one puff. R1 then, without rinsing his mouth first, placed the rest of his medication into his mouth and swallowed them with a glass of water.<br><br>On January 21, 2026, at 8:40 a.m., ULP-B stated they usually put R1's medications on the tray for him because he wants them ready when he gets to the chair. ULP-B further stated they did not usually ask residents to rinse their mouth out after using an inhaler.<br><br>On January 21, 2026, at 8:40 a.m., clinical nurse supervisor (CNS)-A stated staff are taught the correct way to prepare and administer medications. CNS-A further stated she would retrain the staff. | 01760 | | |

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| 01760 | Continued From page 21<br><br>The manufacturer's Quick Guide to Using Your Symbicort Inhaler date 2018, indicated the user should, "rinse your mouth with water. Spit out the water. Do not swallow it."<br><br>The licensee's undated Metered Dose Inhaler Medication-Competency procedure form indicated the ULP should have residents rinse their mouth following inhaler use when indicated.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked and ensure only authorized personnel had access to medications for one of two residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic | 01880 | | |

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| 01880 | Continued From page 22<br>failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's service plan, dated December 18, 2025, indicated R1 received services including assistance with medication administration.<br><br>On January 21, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-B preparing R1's morning medications. ULP-B removed R1's medication basket from a locked cabinet in the kitchen/dining room area and placed R1's medications into a medication cup. ULP-B then retrieved R1's inhaler from the basket and brought all the morning medications to the living room and placed them on a TV tray. ULP-B returned the medication basket to the cabinet and exited the area to assist other residents, leaving R1's medication unattended.<br>-at 7:40 a.m., the surveyor observed R2 sitting at the kitchen table finishing their breakfast. R2 ambulated into the living room and sat in a lounge chair two seats away from the TV tray where R1's unattended medications were located. The surveyor observed ULP-C left the kitchen/dining room area to assist other residents, leaving R2 unattended in the living room along with R1's medication.<br>-at 7:55 a.m., the surveyor observed ULP-C assist R1 ambulating with a walker through the kitchen and into the living room. R1 sat in a chair next to the TV tray and self-administered his medications.<br><br>On January 21, 2026, at 8:40 a.m., ULP-B stated they usually prepared R1's medications and left them on the TV tray because R1 "wants it waiting." ULP-B further stated they used to wait to | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32589 | A. BUILDING: _____ B. WING _____ | 01/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN POND WBL | 4624 STODDART CIRCLE SAINT PAUL, MN 55127 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 23<br><br>prepare the medications but now they know the resident.<br><br>On January 21, 2026, at 8:40 a.m., clinical nurse supervisor (CNS)-A stated staff were taught the correct way to prepare and administer medications and they should not have left them out unattended. CNS-A further stated she would retrain the staff.<br><br>The licensee's Medication Storage policy, dated August 1, 2021, indicated medications managed outside the resident's private living space would be securely locked and only authorized personnel would have access to the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to document an opened date on time sensitive medication for one of two residents (R1).<br><br>This practice resulted in a level two violation (a | 01890 | | |

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| 01890 | Continued From page 24<br><br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's service plan, dated December 18, 2025, indicated R1 received services including assistance with medication administration.<br><br>On January 21, 2026, at 7:25 a.m., the surveyor observed R1's medications with unlicensed personnel (ULP)-B. The medications included a Symbicort (a combination medication used to reduce inflammation and relax airway muscles) inhaler. The inhaler lacked a date to indicate when the medication was first used or when it should be discarded. ULP-B stated they were not sure why the inhaler did not have a date on it.<br><br>On January 21, 2026, at 1:47 p.m., clinical nurse supervisor (CNS)-A stated the staff person who opened the inhaler should have put a date on it and they were not sure why that did not happen.<br><br>The manufacturer's Quick Guide to Using Your Symbicort Inhaler date 2018, indicated the inhaler should be discarded once it is empty or three months after it is removed from the foil pouch, whichever comes first.<br><br>The licensee's Medication Storage policy, dated August 1, 2021, indicated no discontinued or expired medication would be stored in the medication cabinet and medications would be | 01890 | | |

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| 01890 | Continued From page 25<br>stored consistent with the manufacturer's directions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=I | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R1) who utilized consumer-style bed rails, and one of one resident (R2) who utilized hospital-style side bed rails.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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).<br><br>The findings include:<br><br>CONSUMER-STYLE PORTABLE BED RAILS | 02310 | | |

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| 02310 | Continued From page 26<br><br>R1 was admitted on June 8, 2020, and had diagnoses which included Huntington's Disease (a rare disease that causes decay of nerve cells in the brain).<br><br>On January 20, 2026, at 2:00 p.m., the surveyor observed R1's bedroom with unlicensed personnel (ULP)-B. R1's bed included a cane-style consumer bed rail in the upright position on the left upper half of the bed. R1 was observed seated on the side of the bed, and ULP-B assisted R1 with medication administration.<br><br>R1's nursing assessment dated December 9, 2025, indicated, on page 19, bed rails were appropriate and used for support getting in and out of bed. The assessment lacked documentation of:<br>- installation and use according to manufacturer's guidelines;<br>- physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;<br>- documentation of education and discussion with resident or their representative of risks and benefits of bed rails; and<br>- evidence the licensee checked the bed rails were not recalled by the Consumer Product Safety Committee (CPSC).<br><br>HOSPITAL-STYLE BED RAILS<br>R2 was admitted on April 7, 2017, and had diagnoses which included Wernicke's Encephalopathy (a neurological condition caused by thiamine (vitamin B1) deficiency).<br><br>On January 21, 2026, at 10:40 a.m., the surveyor observed R2's bedroom with clinical nurse supervisor (CNS)-A. R2's bed was a | 02310 | | |

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| 02310 | Continued From page 27<br><br>hospital-style bed with bilateral (both sides) upper bed rails. Both bed rails were in the upright position.<br><br>R2's nursing assessment dated December 9, 2025, indicated, on page 19, "full side rail" was being used for mobility in bed. The assessment lacked an accurate description of the side rail that was in use, and lacked documentation of:<br>- installation and use according to manufacturer's guidelines;<br>- physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;<br>- documentation of measurements of Food and Drug Administration (FDA)-identified zones of entrapment.<br><br>On January 21, 2026, at 10:50 a.m., CNS-A stated R1 was placed on hospice care in September and started using a hospital bed at that time. CNS-A stated the consumer style grab bars had been used on R1's previous bed and staff installed the grab bar on the hospital bed. CNS-A further stated she had not done a physical assessment of the consumer grab bar, or the hospital bed rails, and she had not checked for a consumer recall. CNS-A stated she was not aware of the requirement.<br><br>The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must | 02310 | | |

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| 02310 | Continued From page 28<br>be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, 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."<br>Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment:<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."<br>In addition, included, ""If a licensee is unable to locate manufacturer's guidelines, they are unable | 02310 | | |

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| 02310 | Continued From page 29<br>to assess and determine if the portable bed rail is being used appropriately and installed properly."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 02310 | | |
| 02320 SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the steps of the medication administration process were followed for one of three residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's service plan, dated December 18, 2025, indicated R1 received services including | 02320 | | |

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| 02320 | Continued From page 30<br>medication administration.<br><br>A nursing assessment, dated December 9, 2025, indicated R1 required assistance and did not self-administer his own medications.<br><br>R1's medication administration record (MAR) dated January 2026, indicated R1 received Symbicort inhaler (a combination drug of budesonide 80 micrograms (mcg) and formoterol fumarate 4.5 mcg, used to treat asthma) at 8:30 a.m. daily.<br><br>On January 21, 2026, at 7:25 a.m., unlicensed personnel (ULP)-B was observed preparing R1's morning medications. ULP-B removed R1's medication basket from a locked cabinet in the kitchen and placed R1's medications into a medication cup. ULP-B then removed R1's inhaler from the basket and brought all the morning medications to the living room and placed them on a TV tray. ULP-B returned the medication basket to the cabinet and exited the kitchen/dining room area to assist other residents.<br>-at 7:55 a.m., R1 was observed ambulating with a walker through the kitchen and into the living room with the assistance of ULP-C. R1 sat in a chair located next to the TV tray. R1 shook the inhaler, took the cap off the mouthpiece and administered one puff to himself. R1 then, without rinsing his mouth first, placed the rest of his medication into his mouth and swallowed them with a glass of water.<br><br>On January 21, 2026, at 8:40 a.m., ULP-B stated they usually prepared R1's medications and left them on the TV tray because R1 "wants it waiting." ULP-B further stated they used to wait to prepare the medications but now they know the | 02320 | | |

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| 02320 | Continued From page 31<br>resident.<br><br>On January 21, 2026, at 8:40 a.m., clinical nurse supervisor (CNS)-A stated staff are taught the correct way to prepare and administer medications and they should not leave them out unattended.<br><br>The licensee's undated Metered Dose Inhaler Medication-Competency procedure form indicated ULP should, shake the inhaler for five seconds, ensure the individual is in a standing or upright position, instruct the individual to take a deep breath and exhale completely, hold the inhaler upright with the mouthpiece at the bottom, place the mouthpiece of the inhaler into the individual's mouth and instruct them to close their lips around it to form a tight seal. The procedure further indicated ULP would have residents rinse their mouth following inhaler use when indicated.<br><br>The licensee's Medication Storage policy, dated August 1, 2021, indicated medications managed outside the resident's private living space would be securely locked and only authorized personnel would have access to the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

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 POND WBL
4624 Stoddart Circle
St Paul, MN 55127
Ramsey County
Parcel:

Phone:

## License Info

License: HFID 32589

Risk:
License:
Expires on:
CFPM: ELIZAR CEMENI BULAC
CFPM #: 57290; Exp: 4/5/2028

## Inspection Info

Report Number: F8058261023
Inspection Type: Full - Single
Date: 1/20/2026 Time: 10:24:44 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

HRD INSPECTOR TAMMY CARLSON

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

180 DISH MACHINE
41 CHEESE - COOLER
41 TOMATO - COOLER

**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 F8058261023 from 1/20/2026**

ELIZAR CEMENI BULAC
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL32589016 | **Date:** 1/20/2026 |
| **Facility Name:** Golden Pond WBL | |
| **Facility Address:** 4624 Stoddart Circle, White Bear Lake MN 55127 | |

☒ **TAG IDENTIFICATION: 0800**

**SCOPE/ SEVERITY:** Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   *Comments: During tour the surveyor asked clinical nurse supervisor (CNS)-A to open the egress windows in the resident rooms. CNS-A was unable to operate the window because the crank handle was missing a set screw to properly secure it. The handle rotated, but would not open the window.*

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 3; 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 included standard employee procedures but 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) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.*

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

*Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.*

3. 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: During record review CNS-A stated that staff receive training annually on the FSEP. No documentation was provided.*

4. 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. [Minn. Stat. 144G.45 subd.2]

   *Comments: During record review CNS-A stated that residents receive verbal training on the FSEP. No training documentation was provided.*

5. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   *Comments: Documentation provided indicated that drills were conducted every other month, but 4 of the 6 drills were completed on shift change between first and second shift. When asked CNS-A could not articulate what shift was responsible for the drills. Documentation provided indicated that there were no drills completed on the overnight shift.*