Electronically Delivered

April 2, 2025

Licensee
Golden Horizons
13631 East Shore Road
Cross Lake, MN 56442

RE: Project Number(s) SL30621016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30621016 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 31 residents; 31 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year and failed to post a daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 35 residents, with a current census of 31 residents. During the entrance conference on February 24, 2025, at 10:45 a.m., assisted living director in residency (ALDIR)-B and operations director (OD)-D stated they were familiar with the current minimum assisted living requirements. In addition, they stated they had three shifts, with three to four unlicensed personnel (ULP) on the day shift from 6:00 a.m. to 2:00 p.m., three to four ULP on the evening shift from 2:00 p.m. to 10:00 p.m., and two ULP on the night shift from 10:00 p.m. to 6:00 a.m., and added they mostly ran with four on the day and evening shift. The licensee's Assisted Living Facility Staffing Plan dated January 16, 2023, indicated staffing would include two ULP in the assisted living (AL) and two ULP in the memory care (MC) on the day and evening shift, and one ULP in the AL and one ULP in the MC on the night shift. The licensee's Daily Staffing Hours posted schedule dated January 16, 2025, noted the days Monday through Sunday, and included for each	0 470		

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0 470	Continued From page 3 day 8 hours in AL, 8 hours in MC for the morning shift, evening shift, and night shift. However, it did not include the total number of staff working each shift. On February 24, 2025, at 11:25 a.m., ALDIR-B stated a new daily schedule was posted after each review of the staffing plan was completed. On February 26, 2025, at 9:50 a.m., OD-D provided the schedules dated January 16, 2025, April 17, 2024, and August 20, 2023, and stated these were the dates of the most current reviews. OD-D stated the staffing plan was not reviewed at least twice per year as required. The licensee's Staffing Plan policy dated August 1,2021, noted the licensee would complete and evaluation at least twice per year to determine appropriate staffing levels. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	0 480		

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0 480	Continued From page 4 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be	0 480		

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0 480	Continued From page 5 provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary	0 485		

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0 485	Continued From page 6 allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include R1's Residency Agreement dated December 20, 2021, noted on page 2, "Meals and Snacks. Three meals per day, served at regularly scheduled times, fruits and snacks are available throughout the day and are included in the Basic Care Rate as set forth in Section V.S."	0 485		

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0 485	Continued From page 7 On February 26, 2025, at 4:08 p.m., operations director (OD)-D stated the same template was utilized for all residents, and said meals were included in all packages. In addition, OD-D stated a resident could opt out of a meal but would still be charged since it was included in the package. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices;	0 500		

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0 500	Continued From page 8 (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. 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:	0 500		

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0 500	Continued From page 9 The licensee failed to develop the following policy: - supervision of registered nurses and licensed health professionals. On February 26, 2025, at 3:40 p.m., operations director (OD)-D and assisted living director in residency (ALDIR)-B stated the had a policy for supervision of the unlicensed personnel, but not for supervision of the registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 510 SS=D	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of one	0 510		

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0 510	Continued From page 10 employee (unlicensed personnel/ULP-F). 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: On February 25, 2025, at 7:42 a.m., the surveyor observed ULP-F perform a blood glucose check on R2. ULP-F, with gloved hands, wiped R2's right index finger with an alcohol wipe, poked the finger with a lancet, and attempted to get blood for a sample. After not having success with this finger, the ULP-F wiped R2's right middle finger with an alcohol wipe, poked the finger with a new lancet, and placed the blood sample on the test strip. Upon completion, ULP-F placed the lancet in the left gloved hand, removed the glove from her right hand, opened the drawer to the medication cart with the right hand, typed on the computer with the right hand, and then placed the lancet in the sharps container, removed the glove from her left hand, and performed hand hygiene with hand sanitizer. On February 25, 2025, at 8:00 a.m., ULP-F stated she had been trained to use hand sanitizer after performing a blood glucose check and after removing gloves but had not done that with the blood glucose check observed. On February 26, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-A stated she expected hand	0 510		

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0 510	Continued From page 11 hygiene to be performed after a blood glucose check, before touching a clean surface, and after gloves were removed. The licensee's Blood Sugar Testing dated January 1, 2025, noted after performing the test and cleaning the glucometer, staff were to remove gloves and wash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a	0 550		

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	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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

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0 550	Continued From page 12 conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial tour on February 24, 2025, at 11:15 a.m., with assisted living director in residency (ALDIR)-B, the surveyor observed the main entry to the facility opened to a main common sitting area, with a dining room and kitchen, and staff offices. To the left was a locked dementia care unit, with a common sitting area, dining room, and serving kitchen. It also had a hallway with rooms around the perimeter. Past the main area dining room included resident rooms, a theater room, and a chapel. The surveyor observed postings on the office door next to the main entrance. The grievance form was posted. However, it lacked the name, telephone number, and email contact information for the individuals responsible for handling resident grievances and lacked the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On February 24, 2025, at 11:30 a.m., ALDIR-B stated the above required content was not included on the posted grievance form.	0 550		

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0 550	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written	0 680		

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0 680	Continued From page 14 emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial tour on February 24, 2025, at 11:15 a.m., with assisted living director in residency (ALDIR)-B and the surveyor observed the main entry to the facility opened to a main common sitting area, with a dining room and kitchen, and staff offices. To the left was a locked dementia care unit, with a common sitting area, dining room, and serving kitchen. It also had a hallway with rooms around the perimeter. Past the main area dining room included resident rooms, a theater room, and a chapel. A blue Emergency Preparedness binder was located in the small seated area with beverages and snacks off the dining room. At this time, ALDIR-B stated this was one copy, and she had another copy in her office. The licensee's EPP dated October 2023, lacked the following required content: - annual review/updates; - quarterly review of the missing resident plan; - policy and procedure to address safe	0 680		

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0 680	Continued From page 15 evacuation from the facility, including alternative communication means with external sources of assistance; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - a written communication plan including: - primary and alternate means of communicating with facility staff and Federal, State, tribal, regional and local emergency management agencies; - EP training and testing program that must be reviewed and updated annually; - training program to include initial training of new staff and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role and at least annually; - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed.	0 680		

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0 680	Continued From page 16 On February 26, 2025, at 2:05 p.m., ALDIR-B and operations director (OD)-D stated the EPP had not been reviewed since October 2023, but the policies had been reviewed January 1, 2025. In addition, they stated the above required content had not been developed as required, and the missing resident plan was reviewed annually, not quarterly as required. On February 26, 2025, at 10:20 a.m., the surveyor toured the facility with maintenance (M)-H, ALDIR-B, and operations coordinator OC-(I). During the facility tour, the surveyor observed an emergency power generator. During the facility tour interview, ALDIR-B and OC-I verified the emergency power generator was part of the emergency plan. On February 26, 2025, at 12:00 p.m., the surveyor requested generator inspection and testing records from (M)-H. A quarterly generator inspection checklist was provided. During an interview on February 26, 2025, at 12:05 p.m., M-H stated they were not aware weekly generator inspections and monthly load tests were required and verified these inspections and tests had not been completed at the required frequency. The licensee failed to meet the minimum frequency requirements of inspections and testing for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator.	0 680		

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0 680	Continued From page 17 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 775		

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0 775	Continued From page 18 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: On February 26, 2025, at 10:20 a.m., the surveyor toured the facility with maintenance (M)-H, assisted living director in residency ALDIR-(B), and operations coordinator OC-(I). During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - Electromagnetic locks with keypads were installed on emergency exit doors. These exit doors required entry of a code into the keypad to unlock. The electromagnetic door locks could also be unlocked using the fire alarm panel installed in the front entrance. During an interview on February 26, 2025, at 1:15 p.m., with ALDIR-(B) and operations coordinator OC-(I), the above listed observations were verified. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the locks. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. - On February 26, 2025, ALDIR-B and OC-I provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system. During an interview on February 26, 2025, at 1:15 p.m., assisted living director in residency ALDIR-(B) and operations coordinator OC-(I) verified this information was not included in the plan.	0 775		

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0 775	Continued From page 19 Fire Door Maintenance The activity room fire doors were propped open with door stops. The room was unoccupied during the tour. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. During the tour interview, M-H, ALDIR-B, and OC-I verified the above listed fire door observations. Smoking Material Disposal - On February 24, 2025, at 11:15 a.m., the surveyor toured the facility with ALDIR-B. During the facility tour, the surveyor observed burnt cigarettes had been disposed of on the ground in the outdoor courtyard by the assisted living dining room and in the dementia care outdoor patio area. Additionally, an uncovered plastic bucket contained burnt cigarettes and a plastic cup. This bucket was stored next to the side of the building in the dementia care outdoor patio area. - On February 26, 2025, at 10:20 a.m., the surveyor toured the facility with maintenance (M)-H, assisted living director in residency ALDIR-(B), and operations coordinator OC-(I). During the facility tour, the surveyor observed burnt cigarettes were disposed of on the ground in the dementia care outdoor patio area. During the facility tour interview on February 26, 2025, ALDIR-(B) verified smoking materials had been improperly disposed. Improper disposal of smoking materials creates a fire hazard. Emergency Lights Emergency lights did not work when tested by M-H in the corridor between resident rooms 116 and 121, in the dementia care dining room, and at the entrance into the assisted living part of the building from the dementia care unit. The	0 775		

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0 775	Continued From page 20 emergency light was dim when tested by M-H in the south wing corridor across from the whirlpool room. Emergency lights must be maintained in proper operating condition to illuminate escape routes in the event of a fire or power outage. During the tour interview, M-H verified the above listed emergency light observations. Smoke Alarm Installation The smoke alarm in resident room 106 was hanging loose from the ceiling and not installed in the bracket. Smoke alarms must be securely mounted. During the tour interview, M-H verified the smoke alarm required reinstallation. Clothes Dryer Maintenance In the dementia care laundry room, there was an accumulation of lint behind the clothes dryer, creating a fire hazard. During the tour interview, M-H verified the laundry room observation. Extension Cord Use An extension cord was used to supply power in resident room 117, creating a fire hazard. During the tour interview, M-H verified the extension cord observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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	0 800		

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0 800	Continued From page 21 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On February 26, 2025, at 10:20 a.m., the surveyor toured the facility with maintenance (M)-H, assisted living director in residency ALDIR-(B), and operations coordinator OC-(I). During the facility tour, the surveyor observed the following: - The sliding closet doors were off the track in resident rooms 116 ,121, and 208. Additionally, a handle was not installed on the closet door in room 208. - One section of the exterior concrete patio was chipped in the dementia care area. One section of the exterior sidewalk was chipped for the pedestrian walkway between the side door and the front of the building. These areas create a	0 800		

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0 800	Continued From page 22 trip/fall hazard. M-H verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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 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	0 810		

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0 810	Continued From page 23 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 record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 26, 2025, maintenance (M)-H, assisted living director in residency ALDIR-(B), and operations coordinator OC-(I) provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review indicated the licensee FSEP was not developed and maintained for the facility. The FSEP fire policy dated August 1, 2021, was a template from a third-party provider. The FSEP fire policy failed to provide specific employee actions to take in the event of a fire or	0 810		

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0 810	Continued From page 24 similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym. The FSEP failed to identify specific fire protection procedures necessary for residents evident by limited instructions to evacuate. The FSEP must be developed and maintained with procedures specific to the facility and the building occupants. During an interview on February 26, 2025, at 1:45 p.m., ALDIR-B and OC-I verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of documentation. Records were not provided from the last year to support this training had been completed. Record review indicated the licensee failed to provided fire safety and evacuation training to residents at least once per year evident by the lack of documentation. Records were not provided from the last year to support this training had been completed. During an interview, on February 26, 2025, at 1:45 p.m., ALDIR-B and OC-I verified the training frequency was not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per	0 810		

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0 810	Continued From page 25 year, per shift with at least one evacuation drill every other month evident by a review of fire drill logs lacking the required frequency and documentation. Three fire drills were completed between April 2024 and February 2025. Additionally, fire drills had not been conducted during the night shift. The names of the employees who had participated in the drills were not recorded. During an interview, on February 26, 2025, at 1:45 p.m., ALDIR-B and OC-I verified the evacuation fire drill frequency was not met and the required documentation not maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 26 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's start of services was December 20, 2021. R1's Service Plan dated February 1, 2025, noted R1 received services including assistance with dressing and grooming, medication administration, behavior monitoring, and bathing. The licensee lacked a written contract with the following required content: - the contract must include in a conspicuous place and manner the health facility identification (HFID) number; and - the name, telephone number, and physical mailing address of the licensee of the facility. On February 25, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated the same contract template was utilized for all residents On February 26, 2025, at 4:08 p.m., assisted living director in residency (ALDIR)-B and operations director (OD)-D stated the contract included the contract included the license number, and lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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0 930	Continued From page 27	0 930		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 930		

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0 930	Continued From page 28 the residents). The findings include: R1's start of services was December 20, 2021. R1's Service Plan dated February 1, 2025, noted R1 received services including assistance with dressing and grooming, medication administration, behavior monitoring, and bathing. The licensee lacked a written contract with the following required content: - the facility's policy regarding transfer of residents within the facility, under which resident consent is required for a transfer. On February 25, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated the same contract template was utilized for all residents On February 26, 2025, at 4:08 p.m., assisted living director in residency (ALDIR)-B and operations director (OD)-D stated the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01060 SS=D	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.	01060		

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	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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01060	Continued From page 29 (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. (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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01060	Continued From page 30 licensee failed to provide a written notice with the required content for an emergency relocation to the legal representative of the emergency relocation for one of two residents (R1) who were hospitalized. 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: R1's diagnoses included major depressive disorder and diabetes mellitus type 2. R1's Service Plan dated February 1, 2025, noted R1 received services including assistance with dressing and grooming, medication administration, behavior monitoring, and bathing. R1's record contained an Emergency Relocation Notification dated January 17, 2025. On February 25, 2025, at 3:20 p.m., assisted living director in residency (ALDIR)-B stated the relocation had been sent to the Office of Ombudsman for Long-Term Care and sent to the resident at the hospital on January 20, 2025. However, it had not been sent to the resident's legal representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01060	Continued From page 31 (21) days	01060		
01650 SS=E	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 plan included the required content for two of three	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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01650	Continued From page 32 residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included major depressive disorder and diabetes mellitus type 2. On February 26, 2025, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Service Plan dated February 1, 2025, noted R1 received services including assistance with dressing and grooming, medication administration, behavior monitoring, and bathing. It noted "If services to be provided are home care services, an individualized assessment will be conducted in person by a registered nurse. This initial assessment will be conducted within 5 days after initiation of home care services." R3 R3's diagnoses included major depressive disorder and hypertension. R3's Service Plan dated February 1, 2025, noted R3 received services including assistance with bathing, oxygen management, and medication	01650		

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	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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01650	Continued From page 33 administration. It noted "If services to be provided are home care services, an individualized assessment will be conducted in person by a registered nurse. This initial assessment will be conducted within 5 days after initiation of home care services." On February 25, 2025, at 3:20 p.m., clinical nurse supervisor (CNS)-A stated the verbiage for the frequency of assessments was the language from the home care statutes, not the required assisted living statutes. The licensee's Service Plans policy dated January 1, 2025, noted service plans must include the schedule and methods of monitoring reviews or assessments of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
02040 SS=D	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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02040	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to mitigate a safety risk identified in the facility hazard vulnerability assessment of the physical environment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On February 26, 2025, assisted living director in residency ALDIR-(B) and operations coordinator OC-(I) provided a hazard vulnerability assisted living memory care assessment dated August 15, 2024. Chemical exposure was identified as a risk and the mitigation plan directed employees to use locks and perform daily safety checks. On February 26, 2025, at 10:20 a.m., the surveyor toured the facility with maintenance (M)-H, assisted living director in residency ALDIR-(B), and operations coordinator OC-(I). During the facility tour, the surveyor observed chemicals were stored in the cabinet under the sink in the dementia care serving kitchen. Locks had not been installed on the cabinet and the serving kitchen was not staffed. During the facility tour interview, ALDIH-B and OC-I verified the chemical storage observation. TIME PERIOD FOR CORRECTION: Two (2) days	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	02/26/2025

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02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, an accurate description of the dementia care training program with the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective November 1, 2024. During the entrance conference on February 24, 2025, at 10:45 a.m., assisted living director in residency (ALDIR)-B stated the licensee had a locked dementia care unit.	02260		

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02260	Continued From page 36 The licensee's Dementia Disclosure dated reviewed January 1, 2025, noted: - all staff are extensively trained at the time of hire and annually, and "All staff are required to extensively train on dementia and Alzheimer's related disorders including a current explanation of Alzheimer's disease and related disorders, effective approaches to use to problem-solve when working with clients [residents] challenging behaviors, and how to communicate with clients [residents] who have Alzheimer's or related disorders." However, it lacked identification of training to include assistance with activities of daily living and person-centered planning and service delivery. Of February 26, 2025, at 3:55 p.m., regional registered nurse (RN)-C stated the policy lacked the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *02/10/25*
Time: 11:15:43
Report: 1041251035

Food and Beverage Establishment Inspection Report

Location:
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN56378
Stearns County, 73

Establishment Info:
ID #: 0037551
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207321939
ID #:

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

The following orders previously issued on 07/25/22 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE CHLORINE TEST STRIPS FOR BLEACH SANITIZER THAT IS USED FOR FOOD CONTACT SURFACES
2/10/25 SAME.

Issued on: 07/25/22 *Comply By: 07/25/22*

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

KARMEN UECKER HAS PASSED A FOOD SAFETY COURSE, BUT DID NOT APPLY FOR THE STATE CERTIFICATE. SHE WILL NEED TO RETAKE THE FOOD SAFETY COURSE AND APPLY FOR THE STATE CERTIFICATE WITHIN 6 MONTHS OF PASSING THE COURSE.

Comply By: 03/31/25

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

AT TIME OF INSPECTION, THE DISHWASHER WAS OUT OF ORDER. REPAIR OR REPLACE THE DISHWASHER. SANITIZE DISHES IN THE SINK UNTIL DISHWASHER IS REPAIRED.

Comply By: 03/10/25

Food and Equipment Temperatures

Type: Full
Date: *02/10/25*
Time: 11:15:43
Report: 1041251035
Cedar Cove Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1041251035 of 02/10/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Signed:_____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us