



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2025

Licensee

Golden Star Residential Care LLC
8143 Ivywood Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL38982016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 11, 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.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN STAR RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8143 IVYWOOD AVENUE SOUTH COTTAGE GROVE, MN 55016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #38982016-0 On June 9, 2025, through June 11, 2025, 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 2 residents, both 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. 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 660	Continued From page 1 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completing a facility TB risk assessment annually. This had the potential to 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, 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's undated facility risk assessment indicated the facility was at "0" risk for TB transmission.	0 660			

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0 660	Continued From page 2 On June 10, 2025, at 8:00 a.m., owner/clinical nurse supervisor (O/CNS)-A confirmed the TB facility risk assessment provided was the most recent assessment, and stated they completed the assessment "every so often." O/CNS-A further stated she was not sure why the assessment was not dated, and she usually completed it in January. The Minnesota Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated June 2024, indicated a TB facility risk assessment should be performed annually. The licensee's undated Tuberculosis Prevention and Control policy indicated the licensee would complete a TB risk assessment annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	0 730			

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0 730	Continued From page 3 (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident	0 730			

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0 730	Continued From page 4 records included documentation of services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2's signed service plan, dated October 11, 2024, indicated R2 received services including assistance with therapeutic exercises, continence care, transferring, ambulation, and positioning. On June 10, 2025, at 7:00 a.m., ULP-C was observed assisting R2 with transferring and positioning. A document titled, (licensee) Charting Sheet, for the months of May and June 2025, did not include documentation that services were provided as listed in the service plan. On June 10, 2025, at 11:30 a.m., owner/clinical nurse supervisor (O/CNS)-A, identified the (licensee) Charting Sheet as the record used to document services provided to residents. O/CNS-A stated therapeutic exercises, continence care, transferring, ambulation, and positioning were not listed as services to be provided to R2, so the ULP were not documenting that the services were done. O/CNS-A further stated she was sure the ULP were still providing the services because she was	0 730			

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0 730	Continued From page 5 at the facility daily and observed the ULP. O/CNS-A stated the licensee was moving from paper to an electronic medical record system and the above listed items may have accidentally "dropped off," the record. O/CNS-A stated the services should have been documented and she would add the items back to the record as soon as possible. The licensee's 6.08 Service Plan policy, dated September 26, 2022, indicated the licensee would implement and provide all services indicated in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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.	0 810			

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0 810	Continued From page 6 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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 June 11, 2025, at approximately 11:30 a.m..., owner/clinical nurse supervisor (O/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810			

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0 810	Continued From page 7 evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for employees. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that employees should follow in case of a fire or similar emergency. There was general information provided through care providers policies, but they were not specific to the facility and did not contain specific plans for evacuation. The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. O/CNS-A was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. O/CNS-A stated that employees are trained once per year. Employees should be provided training upon hire and at least twice a year thereafter. Record review indicated the licensee failed to provide training to residents at least once per year. O/CNS-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Residents who are capable of assisting in their evacuation	0 810			

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0 810	Continued From page 8 should be provided training at least once a year. During an interview on June 11, 2025, at approximately 11:40 a.m., the surveyor explained the requirements for employee trainings, resident trainings, FSEP documentation, and FSEP storage. O/CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is	01530			

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01530	Continued From page 9 another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee held an Assisted Living Facility license and provided assisted living services as of August 1, 2021.	01530			

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01530	Continued From page 10 ULP-C was hired January 7, 2025, and provided direct care services to residents. On June 10, 2025, at 7:00 a.m., ULP-C was observed assisting R2 with morning activities of daily living. ULP-C's file lacked documentation of at least eight hours of initial dementia training in the required topics, within 160 working hours of the employment start date. On June 10, 2025, at 10:50 a.m., owner/clinical nurse supervisor (O/CNS)-A stated she could not find documentation of ULP-C's initial dementia training and she thought she had six months to complete it. The licensee's undated Dementia Care Training policy indicated direct care staff would complete at least eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced	01770			

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01770	Continued From page 11 by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R2, 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 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: R2 and R3's service plan, signed October 11, 2024, and October 1, 2024, respectively, indicated R2 and R3 each received services including assistance with medication administration. On June 10, 2024, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. ULP-B removed medications from a pre-setup pill organizer and administered the medications to R2. R2 and R3's records each contained a document titled, "medication set-up note." Both notes indicated medications were setup by owner/clinical nurse supervisor (O/CNS)-A on May 5, 12, 19, June 2, and June 9, 2025. The medication set up documentation lacked the following required content:	01770			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN STAR RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8143 IVYWOOD AVENUE SOUTH COTTAGE GROVE, MN 55016		
(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
01770	Continued From page 12 - name of medication; - quantity of dose; - times to be administered; and - route of administration. On June 10, 2025, at 1:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated she was responsible for medication setup for all residents. O/CNS-A further stated she documented the medication setup in a notebook but had not been aware of all the required content that needed to be documented. The licensee's Medication Management-Administration & Setup policy, dated September 26, 2022, indicated the licensed nurse would set up medications in dosage boxes for the resident usually on a weekly basis. The policy lacked wording indicating the nurse would document the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			



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

Page: 1

Establishment Info

Golden Star Residential Care LLC
8143 Ivywood Avenue South
Cottage Grove, MN 55016
Washington County
Parcel:

Phone:

License Info

License: HFID 38982

Risk:
License:
Expires on:
CFPM: Huriya Gerba
CFPM #: FM29494; Exp: 06/08/2028

Inspection Info

Report Number: F1004251040
Inspection Type: Full - Single
Date: 6/9/2025 Time: 11:40:44 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY TAMMY CARLSON.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- SANITIZER USE AND TEST KITS (ESTABLISHMENT USES QUATERNARY AMMONIUM SANITIZER IN A SPRAY BOTTLE. NO SANITIZER WAS MIXED DURING TIME OF INSPECTION)
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES
- PEST CONTROL
- LOGS
- PHYSICAL FACILITIES AND MAINTENANCE

*NO VIOLATIONS OBSERVED DURING TIME OF INSPECTION.

*REPORT WAS DISCUSSED WITH THE OPERATOR, HURIYA, AND WITH THE NURSE EVALUATOR, TAMMY.

*FLOORS ARE LAMINATE TILES, WALLS ARE SMOOTH PAINTED DRYWALL WITH TILE

BACKSPLASH, AND CEILING IS "ORANGE PEEL" TEXTURE. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 F1004251040 from 6/9/2025

Huriya Gerba

Molly Dougherty

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Golden Star Residential Care LLC
Cottage Grove
County/Group: Washington County

Inspection Info

Report Number: F1004251040
Inspection Type: Full
Date: 6/9/2025
Time: 11:40:44 AM

Equipment Temperature: Product/Item/Unit: Ambient Temperature; **Temperature Process:** Cold-Holding

Location: Refrigerator at <40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Ethiopian Dish; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

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Establishment Info

Inspection Info

Golden Star Residential Care LLC
Cottage Grove
County/Group: Washington County

Report Number: F1004251040
Inspection Type: Full
Date: 6/9/2025
Time: 11:40:44 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No