



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 27, 2026

Licensee
Golden Horizons
1109 Lundorff Drive
Sandstone, MN 55072

RE: Project Number(s) SL33254016

Dear Licensee:

On May 7, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 6, 2025 survey.

The Department of Health 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.

At the time of this follow-up survey completed on May 7, 2026, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

The details of the violations noted at the time of this follow-up survey completed on May 7, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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>

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

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, sweeping initial 'S'.

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/07/2026
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
(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 FOLLOW UP SURVEY WITH NEW ORDER 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: SL33254016-2 On May 5, 2026, through May 7, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to surveys completed on February 9, 2026, and November 5, 2025. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following new order was identified.	{0 000}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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:	{0 470}			
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) 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 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	{0 485}	Not reviewed during this survey.		

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{0 650}	Continued From page 3 required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 4 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 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity	0 830	Not reviewed during this survey.		

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0 830	Continued From page 5 of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 830			
{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	{0 930}			

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{0 930}	Continued From page 6 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:	{0 930}	Not reviewed during this survey.		
{01650} SS=F	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:	{01650}			

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{01650}	Continued From page 7 (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:	{01650}	Not reviewed during this survey.		
{01750} SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			

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{01750}	Continued From page 8	{01750}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by:	{01830}	Not reviewed during this survey.		
{01880} SS=D	144G.71 Subd. 19 Storage of medications	{01880}	Not reviewed during this survey.		

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{01880}	Continued From page 9 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	{01910}			

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{01910}	Continued From page 10 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented;	{02110}			

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{02110}	Continued From page 11 (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by:	{02110}	Not reviewed during this survey.		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	{02320}			

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{02320}	Continued From page 12 and the service plan. This MN Requirement is not met as evidenced by:	{02320}	Not reviewed during this survey.		



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March 10, 2026

Licensee
Golden Horizons
1109 Lundorff Drive
Sandstone, MN 55072

RE: Project Number(s) SL33254016

Dear Licensee:

On February 4, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 6, 2025, found not corrected at the time of the February 4, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on February 4, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with the first name "Stephanie" being the most prominent.

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/04/2026
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
(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: SL33254016-1 On February 9, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 5, 2025. At the time of the survey, there were 33 residents; 34 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following order was reissued.	{0 000}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 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:	{0 470}			
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) 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 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	{0 485}	Not reviewed during this survey.		

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{0 485}	Continued From page 2 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:	{0 485}	Not reviewed during this survey.		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	{0 650}			

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{0 650}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			
{0 775} SS=E	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, record review, and	{0 775}	Not reviewed during this survey.		

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{0 775}	Continued From page 4 interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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). The findings include: On February 9, 2026, at 9:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D and clinical operations manager (COM)-H. During the facility tour, the surveyor observed the egress locking had not changed since the November 5, 2026, survey, and was still not compliant on the day of the follow up. During the facility tour interview, COM-H verified the above listed observations and stated a temporary bypass would be used for unlocking the controlled egress system until the licensee received plan approval from Minnesota Department of Health. COM-H stated the licensee was working on the plan review submittal for MDH Engineering Services for egress locking system modifications to bring the facility into compliance with Minnesota State Fire Code Rules. COM-H explained the exterior work for the courtyard gate could not be completed until the ground thawed and the same contractor would be working on corrections for both the controlled egress locking system inside the building and the courtyard gate. COM-H provided a copy of the signed agreement with the licensed	{0 775}			

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{0 775}	Continued From page 5 contractor dated February 6, 2026. Record review of the available documentation indicated the licensee was working on corrective actions from the initial issue of the order on November 5, 2025, to the current date of the follow-up survey. Previous survey findings: On November 5, 2025, at 11:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D and contract manager (CM)-L. During the facility tour, the surveyor observed the following: EXTERIOR EXIT GATE In the secure dementia care unit, an illuminated exit sign was installed above the door leading to an exterior courtyard enclosed by a fence. A key-only lock and pull-style latch were installed at the top of the fence gate. During the facility tour interview, DM-D and CM-L verified the above listed gate observations. All paths of egress must provide unobstructed exiting for the building occupants. Gate latches and other operating devices shall be installed 34 inches minimum and 48 inches maximum above the ground. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. CONTROLLED EGRESS DOOR LOCKING SYSTEM - Electromagnetic locks were installed on the dementia care controlled egress exit doors. Keypads were installed at these doors and required entry of a code into the keypad to	{0 775}			

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{0 775}	Continued From page 6	{0 775}			
{0 810} SS=F	unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview, DM-D and CM-L verified the above listed locking observations. 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 not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}			

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{0 810}	Continued From page 7	{0 810}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{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:	{0 930}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}			

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{01650}	Continued From page 8 (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:	{01650}	Not reviewed during this survey.		
{01750} SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	{01750}			

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{01750}	Continued From page 9 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions This MN Requirement is not met as evidenced by:	{01830}	Not reviewed during this survey.		

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{01830}	Continued From page 10 Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by:	{01830}	Not reviewed during this survey.		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications	{01910}			

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{01910}	Continued From page 11 (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and	{02110}			

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{02110}	Continued From page 12 design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by:	{02110}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	{02310}	Not reviewed during this survey.		

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{02310}	Continued From page 13 This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 2, 2025

Licensee
Golden Horizons
1109 Lundorff Drive
Sandstone, MN 55072

RE: Project Number(s) SL33254016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 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 . . ."

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072		
(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: SL33254016-0 On November 4, 2025, through November 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 34 residents; 34 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	0 470			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (11) develop and implement a staffing plan for 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 observation, interview, and record review, the licensee failed to post a daily staffing schedule with all required content. 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	0 470			

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0 470	Continued From page 2 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 36 residents, with a current census of 34 residents. During the entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On November 4, 2025, at 1:15 p.m., LALD-A stated the licensee's typical unlicensed personnel (ULP) schedule was: -7:00 a.m. until 3:30 p.m., four ULPs were scheduled; -3:00 p.m. until 11:30 p.m., four ULPs were scheduled; and -11:00 p.m. until 7:30 a.m., two ULPs were scheduled. The licensee's Assisted Living Facility Staffing Plan- Matrix last reviewed June 19, 2025, indicated staffing included the following: -Day Shift: two ULPs in the MC (memory care - facility's name for dementia care unit) and two ULPs in the AL (assisted living); -Evening Shift: two ULPs in the MC and two ULPs in the AL; and	0 470			

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0 470	Continued From page 3 -Overnight Shift: one ULP in the MC and one ULP in the AL. During facility tour on November 4, 2025, at 1:27 p.m. through 1:42 p.m., the surveyor observed the licensee's Daily Staffing Schedule dated November 3, 2025, through November 9, 2025, posted at the facility's main entrance. The Daily Staffing Schedule indicated the following each day: -Day Shift: ULPs were scheduled to work 16 hours in the MC and 16 hours in the AL; -Evening Shift: ULPs were scheduled to work 16 hours in the MC and 16 hours in the AL; and -Night Shift: ULPS were scheduled to work 8 hours in the MC and 8 hours in the AL. The licensee's daily staff scheduled did not indicate how many ULPs were scheduled to work each shift. On November 5, 2025, at 2:00 p.m., LALD-A stated when the licensee developed the daily staffing schedule posting, the license combined the total number of hours ULPs were to be working each shift, and the licensee was not aware the staffing schedule needed to include the number of direct-care staff members for each shift. The licensee's Staffing Ratios policy dated January 1, 2025, did not address requirements in the licensee's daily staff schedule posting. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for	0 470			

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0 470	Continued From page 4 each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) 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 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 contract. This had the potential to affect all	0 485			

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0 485	Continued From page 5 residents. This practice resulted in a level one violation (a violation that will cause only 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: During the entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On November 4, 2025, at 1:02 p.m., LALD-A stated the licensee's assisted living contract did not require a resident to include and pay for meals in their contract that the resident does not want. The licensee's Apartment Rental Rates dated March 1, 2024, indicated three meals per day were included in rental rates services. On page two of (licensee name) Residency Agreement (assisted living contract) dated January 2025, Summary of Information indicated Meal Plan: Y (yes)/N (no) if no (dollar amount) will be deducted monthly. Resident assisted living contracts lacked an option for residents to opt out of payment for one or two meals residents would not want. On November 5, 2025, at 2:01 p.m., LALD-A	0 485			

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0 485	Continued From page 6 stated the licensee's assisted living contract allowed residents to choose to opt into three meals per day or opt out of three meals per day, however, the licensee lacked an option for residents to choose one or two meals per day. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650			

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0 650	Continued From page 7 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-E). 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 entrance conference on November 4, 2025, at 1:10 p.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-E was hired on August 29, 2023, to provide direct care services to residents at the assisted living with dementia care facility. On November 5, 2025, at 6:58 a.m., ULP-E stated ULP-E was trained and competency tested by a registered nurse (RN) upon hire. On November 5, 2025, at 7:24 a.m., the surveyor	0 650			

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0 650	Continued From page 8 observed ULP-E administer R4's scheduled morning eye drops. During the observation, the surveyor observed a PureWick Catheter (external catheter used for urine collection) attached to R4's bed. ULP-E stated ULPs assist R4 with the application of the PureWick Catheter every night and empty the PureWick Catheter every morning. ULP-E's employee record contained trainings for PureWick Catheters and Assistive Devices in Health Care dated September 2, 2025, and September 3, 2025. ULP-E's employee record lacked the following competency evaluations: -PureWick Catheter; and -Broda chair. On November 5, 2025, at 2:11 p.m., LALD-A stated clinical nurse supervisor (CNS)-B completed trainings and competency testing upon hire or when a new treatment was provided to a resident. On November 6, 2025, at 11:58 a.m., CNS-B stated CNS-B completed competency testing for all ULPs for the PureWick Catheter and Broda chair, however, CNS-B did not document the competencies in the employee records. The licensee's Employee Records policy dated January 1, 2025, indicated the records must include date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff	0 650			

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0 650	Continued From page 9 training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660			

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0 660	Continued From page 10 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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a TB screen and two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4,	0 660			

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0 660	Continued From page 11 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on March 11, 2025, and the facility was determined to be a low risk level. ULP-E was hired on August 29, 2023, to provide direct care services to residents at the assisted living with dementia care facility. On November 5, 2025, at 7:13 a.m., the surveyor observed ULP-E conduct a blood glucose check for R3. ULP-E's employee record contained a negative QuantiFERON TB Gold Plus (blood test for TB) dated December 10, 2020 (992 days prior to ULP-E's employment start date). ULP-E's record lacked a TB screen and two-step TST or other evidence of TB screening such as a blood draw within 90 days of employment. On November 5, 2025, at 2:15 p.m., regional registered nurse (RRN)-G stated the licensee accepted two-step TSTs or blood draws within 90 days of employment start date, and RRN-G was not sure why ULP-E's record lacked a TB screen and updated two-step TST or blood draw. The licensee's TB and Staff Screening policy dated May 1, 2024, indicated all staff whose essential job functions require work within the same air space of home care clients [sic] shall be screened and tested for TB. New staff shall be	0 660			

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0 660	Continued From page 12 screened for active signs of TB using the Baseline TB Screening Tool. New staff shall have a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool. No staff shall be permitted to begin work where the work involves sharing the air space with home care clients [sic] until the negative results of the first Mantoux are read and documented. QuantiFERON TB-Gold or QuantiFERON TB-Gold InTube are acceptable substitute for a two-step Mantoux. The policy did not address acceptance of an employee's previous TB screening or two-step TST prior to employment. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated a licensee could accept a TST or Interferon-Gamma Release Assays (IGRA-blood draw) dated within 90 days of hire for a new employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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0 775	Continued From page 13	0 775			
0 775 SS=E	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, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. 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: On November 5, 2025, at 11:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D and contract manager (CM)-L. During the facility tour, the surveyor observed the following: EXTERIOR EXIT GATE In the secure dementia care unit, an illuminated exit sign was installed above the door leading to an exterior courtyard enclosed by a fence. A key-only lock and pull-style latch were installed at	0 775			

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0 775	Continued From page 14 the top of the fence gate. During the facility tour interview, DM-D and CM-L verified the above listed gate observations. All paths of egress must provide unobstructed exiting for the building occupants. Gate latches and other operating devices shall be installed 34 inches minimum and 48 inches maximum above the ground. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. CONTROLLED EGRESS DOOR LOCKING SYSTEM - Electromagnetic locks were installed on the dementia care controlled egress exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview, DM-D and CM-L verified the above listed locking observations. - On November 5, 2025, contract manager (CM)-L provided emergency plan documents. Record review of the available documentation indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on November 5, 2025, at 12:30 p.m., CM-L verified these instructions not included in the emergency plan. FIRE DOOR MAINTENANCE The labeled 20 minute fire door for resident room 111 was propped open with a wedge. The room was unoccupied at the time of the tour. During the facility tour interview, DM-D verified the fire	0 775			

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0 775	Continued From page 15 door observations. Fire-resistant rated doors are required to be maintained as designed to automatically close and latch to prevent the spread of smoke and fire to the corridor in the event of a fire. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
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	0 810			

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0 810	Continued From page 16 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, make all parts of the plan readily available, and provide required drills. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 5, 2025, director of maintenance (DM)-D and contract manager (CM)-L 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 of the available documentation indicated the licensee failed to maintain all parts	0 810			

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0 810	Continued From page 17 of the FSEP as readily available. During an interview on November 5, 2025, at 12:30 p.m., CM-L stated residents requiring staff assistance in an emergency had been identified and these records were maintained electronically on the computer. These records were not included with the printed copy of the FSEP. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants. - The FSEP referenced fire doors on magnetic holders that will automatically close upon fire alarm activation and smoke compartment doors but these doors were not identified in the plan. During an interview on November 5, 2025, at 12:30 p.m., DM-D verified the FSEP required revision. - After exit, additional FSEP documentation was emailed to the surveyor. Record review indicated the FSEP lacked evacuation procedures for the individualized unique needs of residents. The resident evacuation acuity level worksheet dated November 5, 2025, identified residents using a number system for employee assistance. Individualized resident evacuation procedures were not included. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill reports lacking the required frequency. Fire evacuation drills were not conducted in 2025 during February or March. Additionally, employees participated in combined fire drills that	0 810			

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0 810	Continued From page 18 were completed during shift changes. During an interview on November 5, 2025, at 12:30 p.m., DM-D and CM-L verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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 observation, interview, and record review, the licensee failed to execute a written assisted living contract with all required content	0 930			

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0 930	Continued From page 19 for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that will cause only 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: During the entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2 was admitted to the licensee on January 9, 2023. R2's Service Plan dated April 25, 2025, indicated R2's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. On November 5, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-K administer R2's scheduled morning medication. R2's (licensee name) Residency Agreement (assisted living contract) was signed on March 13, 2025. R3 R3 was admitted to the licensee on May 6, 2022. R3's Service Plan dated February 1, 2025,	0 930			

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0 930	Continued From page 20 indicated R3's services included medication administration, oxygen management, blood glucose checks, and housekeeping. On November 5, 2025, at 7:13 a.m., the surveyor observed ULP-E conduct a blood glucose check for R3. R3's (licensee name) Residency Agreement (assisted living contract) was signed on March 13, 2025. R4 R4 was admitted to the licensee on September 3, 2025. R4's Service Plan dated September 29, 2025, indicated R4's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. On November 5, 2025, at 7:24 a.m., the surveyor observed ULP-E administer R4's scheduled morning eye drops. R4's (licensee name) Residency Agreement (assisted living contract) was signed on September 3, 2025. R2, R3, and R4's assisted living contract lacked the facility's policy regarding transfer of residents within the facility, under which resident consent is required for a transfer. On November 5, 2025, at 2:06 p.m., LALD-A stated the same contract was used for all residents. Regional registered nurse (RRN)-G stated RRN-G had thought the licensee had transfer within the facility information posted	0 930			

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0 930	Continued From page 21 somewhere, however, no additional documentation was provided to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
01650 SS=F	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.	01650			

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01650	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for three of three residents (R2, R3, R4). 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 entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included Alzheimer's disease, hypertension (HTN- high blood pressure), and major depressive disorder. R2's Service Plan dated April 25, 2025, indicated R2's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. On November 5, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-K administer R2's scheduled morning medication.	01650			

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01650	Continued From page 23 R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), HTN, diabetes, and anxiety. R3's Service Plan dated February 1, 2025, indicated R3's services included medication administration, oxygen management, blood glucose checks, and housekeeping. On November 5, 2025, at 7:13 a.m., the surveyor observed ULP-E conduct a blood glucose check for R3. R4 R4's diagnoses included diabetes and HTN. R4's Service Plan dated September 29, 2025, indicated R4's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. On November 5, 2025, at 7:24 a.m., the surveyor observed ULP-E administer R4's scheduled morning eye drops. R2, R3, and R4's service plans indicated the initial resident assessment will be completed within 5 (five) days after initiation of home care services. R2, R3, and R4's service plans lacked the schedule and methods of monitoring assessments of the residents per assisted living regulations. On November 6, 2025, at 11:58 a.m., clinical nurse supervisor (CNS)-B stated the licensee	01650			

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01650	Continued From page 24 followed the following assessment cycle for residents: preadmission assessment, admission assessment, 14-day assessment, and then an assessment is completed at least every 90 days, if the resident did not have a change in condition. CNS-B further stated the licensee's electronic medical record system auto filled the verbiage in all resident service plans, which was not a reflection of when the licensee completed resident assessments. The licensee's Service Plans policy dated January 1, 2025, indicated the service plan must include the schedule and methods of monitoring reviews or assessments of the client (resident). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	01750			

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01750	Continued From page 25 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for two of four residents (R2, R5) whose medication administration was delegated to unlicensed personnel (ULP). 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: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included Alzheimer's disease, hypertension (HTN- high blood pressure), and major depressive disorder. R2's Service Plan dated April 25, 2025, indicated R2's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. R2's record lacked a current order for Nystatin 100,000 unit/gram.	01750			

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01750	Continued From page 26 R2's Med (medication) Admin (administration) Summary- Actual- Month dated October 2025, and November 2025, respectively, indicated Nystatin 100,000 units/gram apply small amount topically to affected area's [sic] twice daily. On November 5, 2025, at 8:04 a.m., the surveyor observed ULP-K administer R2's scheduled morning medication. R2's record lacked resident specific instructions for the administration of where to apply Nystatin 100,000 unit/gram. On November 6, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated CNS-B needed to get clarification of where to apply R2's Nystatin since the order did not give specific instructions. R5 R5's diagnoses included HTN, chronic pain, and heart failure. R5's Service Plan dated April 28, 2025, indicated R5's services included medication administration, TEDS (compression stockings), and assistance with bathing, grooming, and dressing. R5's prescriber orders dated November 27, 2024, included an order for diclofenac sodium 1% gel apply topically to affected area(s) twice daily. R5's Med (medication) Admin (administration) Summary- Actual- Month dated October 2025, and November 2025, respectively, indicated diclofenac sodium 1% gel apply topically to affected area(s) twice daily.	01750			

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NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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01750	Continued From page 27 R5's record lacked resident specific instructions for the administration of where to apply the diclofenac sodium 1% gel. On November 6, 2025, at 12:03 p.m., CNS-B stated R5's diclofenac sodium 1% gel was supposed to be applied to R5's knees and shoulders, however, specific instructions on where to apply where not included on R5's electronic medication administration record (EMAR) and the instructions should have been listed. The licensee's Medication Management Services policy dated January 1, 2025, indicated the RN will develop an individualized medication management plan, which included documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760			

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01760	Continued From page 28 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of eight residents (R9) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R9's diagnoses included moderate dementia without behavioral disturbance, diabetes, and chronic pain. R9's Service Plan dated February 1, 2025, indicated R9's services included medication administration 13 times per day.	01760			

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01760	Continued From page 29 R9's prescriber orders dated December 30, 2024, included an order Voltaren 1% apply 2 (two) grams (g) topically to left knee four times per day. R9's Med (medication) Admin (administration) Summary- Actual- Month dated October 2025, and November 2025, respectively, indicated Voltaren 1% gel apply 2 g topically to left knee four times per day. On November 5, 2025, at 11:29 a.m., the surveyor observed unlicensed personnel (ULP)-H apply approximately a grape size amount of Voltaren 1% gel to R9's left knee. The surveyor did not observe ULP-H use a dosing card to verify 2 g of Voltaren 1% gel. On November 5, 2025, at 1:39 p.m., ULP-H stated ULP-H administered a "squirt" size of Voltaren 1% gel to R9's left knee. ULP-H further stated R9's Voltaren 1% gel did not come with a dosing card for measuring the current amount of Voltaren 1% gel. On November 5, 2025, at 2:25 p.m., regional registered nurse (RRN)-G stated the licensee did not have a size reference or dosing card for ULPs to administer 2 g of Voltaren 1% gel for R9. On November 6, 2025, at 12:12 p.m., clinical nurse supervisor (CNS)-B stated CNS-B did not receive a dosing card from the pharmacy for R9's Voltaren and would need to check back with the pharmacy. The manufacturer's instructions for Voltaren dated July 2009, indicated the proper amount of Voltaren Gel should be measured using the	01760			

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01760	Continued From page 30 dosing card supplied in the drug product carton. In addition, the dosing card should be used for each application of drug product. The licensee's Medication Errors policy dated January 1, 2025, indicated the person responsible for the error or the person who caught the medication error will contact the on-call nurse, and the situation explained in detail with the medication name, dosage, and amount given as well as the tenant (resident) involved. The licensee's Medication Management Services policy dated January 1, 2025, indicated the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN (registered nurse) including the complete procedure of checking a client's (resident's) MAR (medication administration record), the preparation of the medication for administration, and the administration of the medication to the client (resident). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01830			

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01830	Continued From page 31 review, the licensee failed to renew prescriptions at least every 12 months for one of three 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: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R2 was admitted to the licensee on January 9, 2023. R2's diagnoses included Alzheimer's disease, hypertension (HTN- high blood pressure), and major depressive disorder. R2's Service Plan dated April 25, 2025, indicated R2's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. R2's Med (medication) Admin (administration) Summary- Actual- Month dated October 2025, and November 2025, respectively, indicated the following medications were scheduled and administered:	01830			

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01830	Continued From page 32 -aspirin 81 (heart health) milligrams (mg) daily -furosemide (diuretic) 20 mg twice daily -morphine (for pain) 5 mg twice daily -Nystatin (antifungal) 100,000 units twice daily -pantoprazole (antacid) 40 mg daily -Senna (for constipation) 8.6 mg daily -Venlafaxine Er (antidepressant) 225 mg daily -Voltaren (for pain) 1% gel twice daily -Quetiapine (antianxiety) 25 mg daily On November 5, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-K administer R2's scheduled morning medications. R2's record included signed prescriber orders dated April 13, 2023, which included orders for aspirin, Quetiapine, and Venlafaxine Er, however, lacked orders for the other noted medications. On November 6, 2025, at 11:44 a.m., regional registered nurse (RRN)-F stated clinical nurse supervisor (CNS)-B realized R2's prescriber orders were not signed when the surveyor requested to review R2's most recent prescriber orders. On November 6, 2025, at 12:31 p.m., CNS-B stated CNS-B had faxed R2's prescriber orders to the physician for a signature today (November 6, 2025) after realizing R2's record did not contain signed annual prescriber orders. CNS-B further stated CNS-B usually received annual signed orders for each resident. The licensee's Medication and Treatment orders policy dated January 1, 2025, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication, treatment or therapy order at least	01830			

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01830	Continued From page 33 every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for one of eight 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: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the	01880			

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01880	Continued From page 34 facility. R2's diagnoses included Alzheimer's disease, hypertension (HTN- high blood pressure), and major depressive disorder. R2's Service Plan dated April 25, 2025, indicated R2's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. R2's Assessment dated August 19, 2025, indicated medications will be stored in a locked medication cart. In addition, per family, resident and registered nurse (RN) face to face assessment, self-administration is not appropriate. Facility provides medication and administration. On November 5, 2025, at 6:39 a.m., the surveyor observed unlicensed personnel (ULP)-I and ULP-J change R2's brief and repositioned R2 in bed. During the observation, the surveyor observed a container of Aquaphor, opened tube of zinc oxide, opened tube of Diclofenac 1% gel, and an open container of antifungal powder sitting in a tote on R2's minifridge near R2's bed. ULP-I stated R2's topical medications were stored in R2's room to access for a brief change or to use after a bath. On November 5, 2025, at 8:04 a.m., the surveyor observed ULP-K administer R2's scheduled morning medication. ULP-K stated R2's creams were stored in R2's room and not stored in a secure medication cart. On November 5, 2025, at 2:28 p.m., regional registered nurse (RRN)-G stated all resident	01880			

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01880	Continued From page 35 medications were stored in locked medication carts unless the resident was assessed to safely store medications in their room. On November 6, 2025, at 12:27 p.m., clinical nurse supervisor (CNS)-B stated R2's medications were to be stored in a secured medication cart, however, CNS-B had just become aware of topical medications stored in R2's room. CNS-B further stated CNS-B had thought hospice had just brought in the medications to R2's room and staff had not secured the medications in the medication cart yet. The licensee's Storage of Medications policy dated January 1, 2025, indicated (licensee name) stores client's (resident's) medications in locked medication cabinets, or locked medication carts. Stored medications are kept locked at all times other than while a staff person is present at the time of medication administration or medication management. In addition, medications stored outside of the medication cabinets, are locked in the medication storage cabinet in the locked nurse's office. Only delegated medication administration staff and nurses have keys to access these medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890			

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01890	Continued From page 36 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in one of three secured medication carts (South medication cart). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. On November 5, 2025, at 1:23 p.m., unlicensed personnel (ULP)-H stated clinical nurse supervisor (CNS)-B was responsible to check medications carts for expired medications. On November 5, 2025, at 1:37 p.m., the surveyor reviewed the South medication cart with ULP-H and observed an open bottle, approximately ¼ full, of acetaminophen 500 milligrams (mg)	01890			

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01890	Continued From page 37 tablets with an expiration date of June 2024. On November 5, 2025, at 2:27 p.m., regional registered nurse (RRN)-G stated the nurse was responsible to complete medication cart audits biweekly (every other week) and monitor for expired medications. On November 6, 2025, at 12:13 p.m., CNS-B stated CNS-B completed medication cart audits biweekly, however, CNS-B must have missed the expired acetaminophen bottle. The licensee's Medication Destruction policy dated January 1, 2025, indicated expired medications managed by (licensee name) will disposed [sic] of according to the accepted practices of the Minnesota board [sic] of Pharmacy and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910			

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01910	Continued From page 38 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. The licensee's Discharged Resident/Client Roster dated June 1, 2025, through November 4,	01910			

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01910	Continued From page 39 2025, indicated R1 was admitted to the facility on September 18, 2025, and discharged on October 8, 2025. R1's diagnoses included biventricular heart failure, hypertension (HTN- high blood pressure), and diabetes. R1's Service Plan dated September 26, 2025, indicated R1 received medication administration four times per day. R1's Med (medication) Admin (administration) Summary- Actual- Month dated September 2025, and October 2025, respectively, indicated R1 received or was prescribed the following medications: -levothyroxine (for underactive thyroid) 137 micrograms (mcg) daily -aspirin (for heart health) 81 milligrams (mg) daily -Breo Ellipta (for asthma) 200-25 mcg inhale one puff daily -Carbamazepine XR (anticonvulsant) 400 mg three times daily -clotrimazole (antifungal) 1% apply topically to affected areas twice daily -Fluticasone (for allergies) 50 mcg two sprays into each nostril daily -furosemide (diuretic) 20 mg daily -lamotrigine (mood stabilizer) 100 mg twice daily -losartan (antihypertensive) 25 mg daily -Nystatin (antifungal) 60 grams (g) apply topically to groin twice daily -Sildenafil (antihypertensive) 20 mg three times daily -Spironolactone (for heart failure) 25 mg daily -Synjardy XR (for diabetes) 12.5-1000 mg two tablets daily -atorvastain [sic] (for cholesterol) 40 mg daily	01910			

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NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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01910	Continued From page 40 -Clobetasol (for inflammatory skin) 0.05% apply to affected area twice weekly R1's prescriber orders dated September 16, 2025, included the above noted medications. R1's Discharge Care Plan dated October 6, 2025, indicated R1 was deceased on October 6, 2025, at a hospital. R1's Medication Destruction/Disposition Log dated October 6, 2025, included medications noted above, however, lacked the medication disposition of Breo Ellipta, clotrimazole cream, Fluticasone, and Nystatin. On November 6, 2025, at 12:22 p.m., clinical nurse supervisor (CNS)-B stated CNS-B could not answer "off the top of my head" and would have to check on the missing four medications not listed on the medication disposition record. CNS-B further stated the licensee used two staff members to sign off on medication disposition for all medications and have the medication disposition documented in a binder. The licensee's Medication Destruction policy dated January 1, 2025, indicated upon disposition of medications, (licensee name) will document the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given or how it was disposed of, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
(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
01910	Continued From page 41	01910			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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02110	Continued From page 42 move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. 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 entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The facility held an Assisted Living with Dementia Care license effective July 1, 2025, through June 30, 2026. The licensee's (licensee name) Dementia Disclosure dated January 1, 2025, provided to each resident and/or resident's legal and designated representatives upon move in, did not	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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02110	Continued From page 43 address the following required policies and procedures: - description of family support programs and efforts to keep the family engaged; - limiting the use of public address for emergencies and evacuation drills only; and - transportation coordination and assistance to and from outside medical appointments. On November 6, 2025, at 12:15 p.m., LALD-A stated LALD-A would have to review the licensee's other polices to address the topics noted above and provide to the surveyor, however, no additional policies were provided to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with a consumer bed rail.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072			
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02310	Continued From page 44 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 entrance conference on November 4, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R4's diagnoses included diabetes and hypertension (HTN- high blood pressure). R4's Service Plan dated September 29, 2025, indicated R4's services included medication administration, and assistance with bathing, grooming, dressing, and toileting. On November 5, 2025, at 7:24 a.m., the surveyor observed ULP-E administer R4's scheduled morning eye drops. During the observation, the surveyor observed a portable bed rail on each side of R4's bed. R4 stated R4 used the bed rails to reposition and sit up in bed. R4's Rails/Bar Assessment dated September 3, 2025, indicated R4 had bilateral side (bed) rails installed securely and in good working order and the bed rails met the FDA (Food and Drug Administration) 2006 recommendations. R4 was ambulatory, did not have mobility limitation, no	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
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02310	Continued From page 45 history of falls, did not require transfer assistance, was orientated and cognitively able to assess safety, and R4 was not on any medications that would increase safety hazards. In addition, the bed rails were not being used as a restraint. The risk and benefits were discussed. R4's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) website for bedrail recall information with the requirement included in the uniform assessment tool for assessing assistive devices. On November 6, 2025, at 12:05 p.m., clinical nurse supervisor (CNS)-B stated the licensee checked for consumer bed rail recalls upon installation of the consumer bed rails and then at least yearly for any resident with a consumer bed rail, however, CNS-B stated the licensee did not document the CSPC website was reviewed. The licensee's Siderails policy dated January 1, 2025, indicated when (licensee name) is aware a home care client (resident) is utilizing siderails (a medical device) on a bed, (licensee name) shall assess the use, educate the client (resident), and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use is a safe design and utilized consistent with the manufacturer's directions [sic]. The policy did not address checking the CSPC website for recalls. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
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02310	Continued From page 46 status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 13, 2025, "Documentation about a resident's consumer bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
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02310	Continued From page 47 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 LUNDORFF DRIVE SANDSTONE, MN 55072		
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02320	Continued From page 48 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. ULP-E was hired on August 29, 2023, to provide direct care services to residents at the assisted living with dementia care facility. ULP-E's employee record indicated ULP-E was trained and deemed competent to administer oral medications on September 24, 2024. The competency indicated after checking the six rights of medications, encourage the client (resident) to take medication with full glass of water, check client's (resident's) mouth for pocketing, if indicated, and document the administration on the medication administration record (MAR). On November 5, 2025, at 6:58 a.m., ULP-E stated ULP-E was trained and competency tested by a registered nurse (RN) upon hire including medication administration. On November 5, 2025, at 7:43 a.m., the surveyor observed ULP-E verify R4's medications with the electronic medication administration record	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2025
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02320	Continued From page 49 (EMAR), place the medications into a plastic medication labeled with R4's name and room number, and then placed the medication cup in the top left drawer of the East medication cart. ULP-E stated ULP-E would administer R4's oral medications when R4 arrived at the dining room for breakfast. On November 5, 2025, at 7:48 a.m., the surveyor observed ULP-E verify R5's medications with the EMAR, placed R5's medications into a plastic cup labeled with R5's room number, and placed the medication cup in the top drawer of the East medications cart. On November 5, 2025, at 8:14 a.m., ULP-E stated most residents took their oral medications with breakfast. On November 5, 2025, at 8:21 a.m., the surveyor observed ULP-E remove R4's medication cup from the top drawer of the East medication cart, placed R4's medication cup at the table where R4 was seated, and returned to the East medication cart. The surveyor did not observe ULP-E administer R4's oral medications. On November 5, 2025, at 8:23 a.m., the surveyor observed ULP-E verify R6's medications with the EMAR, placed R6's medications into a plastic cup, and placed the medication cup at the table where R6 was seated. The surveyor did not observe ULP-E administer R6's oral medications. On November 5, 2025, at 8:34 a.m., the surveyor observed R4 and R6 still seated at the dining room table eating breakfast. R4 and R6's medication cups still had pills inside the medication cups, which had not been	02320			

Minnesota Department of Health

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02320	Continued From page 50 administered. On November 5, 2025, at 2:22 p.m., regional registered nurse (RRN)-G stated ULPs were trained to administer oral medications immediately after verification with the resident's EMAR and to never leave medications in a resident's room. On November 6, 2025, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated ULPs were expected to administer medications right after verification with the resident's EMAR, observe the resident to take the medication, and then return to the computer to document the administration of medications. The licensee's Medication Management Services policy dated January 1, 2025, indicated the ULP must demonstrate their ability to competently follow the delegated medication administration to an RN, which included the administration of the medications to the client and the documentation after medication administration. In Addition, an RN will periodically supervise ULPs performing medication management services to assure proper technique and identify any additionally [sic] training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

GOLDEN HORIZONS
1109 LUNDORFF DRIVE
Sandstone, MN 55072
Pine County
Parcel:

Phone:

License Info

License: HFID 33254

Risk:
License:
Expires on:
CFPM: LISA HENGEL
CFPM #: FM118236; Exp: 7/5/2026

Inspection Info

Report Number: F1016251112
Inspection Type: Full - Single
Date: 11/5/2025 Time: 11:00 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 Duluth District Office inspection report number F1016251112 from 11/5/2025

LISA HENGEL
HEAD COOK


Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Page: 1

Establishment Info

GOLDEN HORIZONS
Sandstone
County/Group: Pine County

Inspection Info

Report Number: F1016251112
Inspection Type: Full
Date: 11/5/2025
Time: 11:00 AM

Food Temperature: Product/Item/Unit: CHICKEN; **Temperature Process:** Cooking

Location: Oven at 175 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: SWEET POTATOES; **Temperature Process:** Hot-Holding

Location: Steam Table at 157 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: PEAS; **Temperature Process:** Hot-Holding

Location: Steam Table at 182 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN; **Temperature Process:** Cold-Holding

Location: Walk-in Freezer at Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
GOLDEN HORIZONS	Report Number: F1016251112
Sandstone	Inspection Type: Full
County/Group: Pine County	Date: 11/5/2025
	Time: 11:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 162 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Greater Than** 200 PPM

Comment:

Violation Issued?: No