Electronically Delivered

January 23, 2026

Licensee
Golden Touch Health Care LLC
5012 66th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL41098015

Dear Licensee:

On December 9, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 17, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

October 28, 2025

Licensee
Golden Touch Health Care LLC
5012 66th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL41098015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 17, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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
Per 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 residents/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 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 the Department of Health 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

DeVries Casey, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41098	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	5012 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL41098015-0 On September 15, 2025, through September 17, 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 two residents both of whom received services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have statements of specific measures to be taken to minimize the risk of abuse to a resident and other vulnerable adults for two of two residents (R1, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 630		

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0 630	Continued From page 4 The findings include: R1 R1 was admitted to the licensee on May 9, 2025, for assisted living services. R1's diagnoses included diabetes, attention deficit hyperactivity disorder (ADHD) and schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination). R1's clinical updated assessment dated August 16, 2025, indicated R1 had the following vulnerabilities: risk to be abused, risk to abuse other vulnerable adults, and risk to abuse themselves. R2 R2 was admitted to the licensee on June 18, 2025, for assisted living services. R2's diagnoses included diabetes, stiff-man syndrome, schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's Individual Abuse Prevention Plan dated June 18, 2025, indicated R2 had the following vulnerabilities: risk to be abused, risk to abuse other vulnerable adults, and risk to abuse themselves. R1 and R2's assessment lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable	0 630		

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0 630	Continued From page 5 adults. On September 16, 2025, at 1:20 p.m., registered nurse (RN)-B stated they were aware the residents' assessments needed interventions for identified vulnerabilities. RN-B also stated they forgot to include in the assessments the statements of the specific measures to be taken to minimize the risk of abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a	0 660		

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0 660	Continued From page 6 tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included training and assessing for current symptoms of active TB disease for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment form dated May 5, 2025, indicated the facility was at a low risk for TB transmission. ULP-C ULP-C started employment with the licensee on March 8, 2025, to provide assisted living services. ULP-C's record included a baseline TB screening tool dated June 19, 2025, which indicated ULP-C completed TB history and symptom screen and two step tuberculin skin testing on June 21, 2025, and July 3, 2025, and the results were negative for TB. ULP-C's record lacked TB Training at hire. ULP-D ULP-D started employment with the licensee on	0 660		

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0 660	Continued From page 7 August 8, 2025, to provide assisted living services. ULP-D's record included a TB gold test which indicated ULP-D was negative for TB, and a completed TB training both dated August 12, 2025. ULP-D's record lacked a TB history and symptom screen at hire. On September 17, 2025, at 10:20 a.m., licensed assisted living director (LALD)-E stated they forgot to assign required TB training to ULP-C at hire. LALD-E also stated they could not explain how the assessment for current symptoms of active TB was missing from the employee record for ULP-D. The licensee's Tuberculosis Screening/Prevention Policy dated August 1, 2021, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements. - risk assessment; - TB screening; and - staff education. The Minnesota Department of Health's Regulations for TB Control in Minnesota Health Care Settings dated April 3, 2025, indicated the suggested components of an initial TB training and education program to include clinical information, epidemiology of TB, and infection-control practices to prevent and detect M. tuberculosis transmission in health-care settings.	0 660		

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0 660	Continued From page 8 The Minnesota Department of Health's (MDH) Assisted Living Resources and Frequently Asked Questions (FAQs) dated July 1, 2025, indicated Baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This 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).	0 775		

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0 775	Continued From page 9 The findings include: On September 17, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A and unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: SMOKING MATERIAL DISPOSAL Burnt cigarettes were disposed of on the ground in the front of the building below the ramp. A disposal container for smoking materials was not provided. LALD/O-A stated during the facility tour that none of the current residents smoked cigarettes, they vaped. During an interview on September 17, 2025, at 12:15 p.m., ULP-C verified there were burnt cigarettes on the ground. Containers of an approved style shall be provided for smoking material disposal. ELECTRICAL - There were exposed capped electrical wires on the upper wall in the main floor bathroom. The door to this bathroom was not locked during the facility tour. - There were gaps between the light switch cover and the drywall in the main floor hallway outside the bathroom. Capped electrical wires shall not be exposed in areas accessible to residents. Wall switch cover plates shall be installed without gaps to prevent exposure to electrical wires. During the facility tour interview, LALD/O-A verified the above listed observations and stated the bathroom was currently being remodeled. SMOKE ALARMS Tape had been placed over the smoke alarm	0 775		

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0 775	Continued From page 10 sensors in the hallway outside the resident sleeping rooms on the main floor and in unoccupied resident room 2. During the facility tour interview, LALD/O-A verified the above listed smoke alarm observations and stated they did not know why the tape had been installed. EGRESS MAINTENANCE There was a large volume of pine cones and pine needles that had accumulated in the bottom of the egress window well for occupied resident room 5. Egress window wells must be maintained to ensure a clear escape path. During the facility tour interview, LALD/O-A verified the above listed observation. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 11 with regard to the health, safety, and well-being of the residents. 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 September 17, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A and unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: - The window blind was damaged in occupied resident sleeping room 3. - The bedroom door did not close and latch for unoccupied resident sleeping room 4. - Unoccupied resident sleeping room 2 was used for storage of remodeling supplies and the cover for one wall vent was not installed. - The light fixture in the main floor hallway outside of the bathroom was not working. - There was an accumulation of pine needles on top of the gutter on the back of the building. - There was an exterior wood deck on the back of the building. One railing was noted as loose.	0 800		

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	41098	A. BUILDING: _____ B. WING _____	09/17/2025

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0 800	Continued From page 12 There were several floor boards and a deck handrail in disrepair. The finish on the deck boards and railings was peeling and/or worn off in numerous locations. During the facility tour interview, LALD/O-A verified the above listed observations. - The drywall was soiled in the corner at the base of the wall behind the desk in the basement office area. During an interview on September 17, 2025, at 12:15 p.m., ULP-C verified the above listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 13 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and maintain the plan as readily available. 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 September 17, 2025, licensed assisted living director/owner (LALD/O)-A provided documents	0 810		

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0 810	Continued From page 14 on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to identify the location and number of resident sleeping rooms and the emergency exit doors for the building evident by the following: - On September 17, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed LALD/O-A verbally identified resident sleeping rooms as 1, 2, 3, 4, and 5. Room number identifiers were not posted on or at the resident sleeping room doors. Number identifiers must be installed on or at the resident sleeping room doors and correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. - LALD/O-A verbally identified the front and side doors as emergency exits for the building during the facility tour. The posted floor plan, dated August 25, 2024, used a round black and white symbols to identify the exit doors. These doors were not clearly labeled as exits on the posted floor plans. Exit door labels are required to be included on the floor plan in order to direct occupants to the designated exits in the event of an emergency. - Record review of the available documentation indicated the licensee failed to develop the FSEP with site specific procedures for the facility and building occupants. The FSEP had been created	0 810		

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0 810	Continued From page 15 using templates from a third party provider. Fire doors, smoke doors, and pull fire alarms were inaccurately referenced. The 4.11. lock down procedures inappropriately instruct employees to prevent entry in the event of a fire. - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. - The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. - The FSEP failed to include site specific actions for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures in the plan. - The FSEP was stored in a locked dining room closet. The FSEP was not maintained as readily available. During an interview on September 17, 2025, at 12:15 p.m., unlicensed personnel (ULP)-C verified the above listed findings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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,	0 830		

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0 830	Continued From page 16 regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity 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 obtain a building permit and submit a Minnesota Department of Health engineering services plan review application for facility construction projects. 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 September 17, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, the surveyor observed the following: - There was unfinished drywall on the walls in the bathroom and in the hallway outside the bathroom. - A bathroom sink was not installed.	0 830		

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0 830	Continued From page 17 - A walk-in-shower was installed with open studs and unfinished drywall visible above the shower stall, indicating this walk-in shower had been newly installed. - There were areas around the bathroom door frame where flooring was not installed, indicating reframing of the door opening had been made in an attempt to meet accessibility standards. During the facility tour interview, LALD/O-A stated the facility was only replacing the tile in the bathroom, no door framing had been altered, and the walk-in shower was not new. LALD/O-A stated a local building permit was not required for the facility remodeling projects. During an interview on September 17, 2025, at 12:15 p.m., unlicensed personnel (ULP)-C stated a new shower and larger door had been recently installed to make the main floor bathroom more accessible for the resident in room 3. - There was an unused bore hole in the door frame for resident room 3 and the floor boards on one side of the frame did not match indicating the door had been replaced and the width opening increased. The width of the installed sleeping room door for resident room 3 measured 32 inches. The width of the installed sleeping room doors for sleeping rooms 1 and 2 measured 30 inches. During an interview on September 17, 2025, at approximately 12:05 p.m., resident (R)-1 stated they were unable to walk, a new door had been installed, and that the door opening had been made larger for better accessibility. Record review indicated a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the bathroom remodeling project and door reframing in resident sleeping room 3.	0 830		

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0 830	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 19 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D started employment with the licensee on August 8, 2025, to provide assisted living services. ULP-D's record lacked evidence ULP-D had completed training evaluations in the following areas: - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and	01370		

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01370	Continued From page 20 - awareness of commonly used health technology equipment and assistive devices. On September 17, 2025, at 10:37 a.m., licensed assisted living director (LALD)-E stated all employees received required training during orientation and before providing services to the licensee's residents. LALD-E also stated that ULP-D had been assigned the training topic however, they had not completed the training. The licensee's Unlicensed Personnel Training Policy dated August 1, 2021, indicated training and competency evaluations for all ULPs will include training on the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 21 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D started employment with the licensee on August 8, 2025, to provide assisted living services. ULP-D's record lacked evidence ULP-D had completed training evaluations in the following areas: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and	01380		

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01380	Continued From page 22 developmental needs of the resident. On September 17, 2025, at 10:37 a.m., licensed assisted living director (LALD)-E stated all employees received required training during orientation and before providing services to the licensee's residents. LALD-E also stated that ULP-D had been assigned the training topic however, they had not completed the training. The licensee's Unlicensed Personnel Training Policy dated August 1, 2021, indicated training and competency evaluations for all ULPs will include training on the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 23 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-C ULP-C started employment with the licensee on March 8, 2025, to provide assisted living services. On September 16, 2025, at 9:12 a.m., the surveyor observed ULP-C prepare and administer medications to R2.	01440		

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01440	Continued From page 24 ULP-D ULP-D started employment with the licensee on August 8, 2025, to provide assisted living services. R2's medication administration record (MAR) dated September 2025, indicated both ULP-C and ULP-D administered medications to R2 ULP-C and ULP-D's employee records lacked a 30-day supervision. On September 16, 2025, at 1:50 p.m., registered nurse (RN)-B stated they were aware of the requirement. RN-B also stated they had not completed 30-day supervision for any of their employees as it had skipped their minds. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision of home health aides performing delegated tasks would be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia	01530		

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01530	Continued From page 25 topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41098	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	5012 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01530	Continued From page 26 Based on interview and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of three employees (registered nurse (RN)-B). 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: RN-B was hired on June 16, 2025, to provide direct care services to residents. On September 16, 2025, at 1:38 a.m., RN-B stated they had not completed mental illness training and stated, "I have to go do that, I will assign it to myself." On September 17, 2025, at 10:45 a.m., licensed assisted living director (LALD)-E stated they had not completed their training audit to know their employees' status. LALD-E also stated they were responsible to audit staff training record and that they had been busy and they forgot to complete the training audit. The licensee's Orientation to Mental Health Policy, dated July 1, 2025, indicated, staff including licensed professionals who provides services to vulnerable adults at Golden Touch will receive a minimum of 2 hours of mental health	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41098	A. BUILDING: _____ B. WING _____	09/17/2025

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01530	Continued From page 27 illness, de-escalation strategies and understanding of how to support people diagnosed with mental health who are in our care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41098	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	5012 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01940	Continued From page 28 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all the services for one of one resident (R2) who received blood glucose monitoring. 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: R2 was admitted to the licensee on June 18, 2025, for assisted living services. R2's diagnoses included diabetes, stiff-man syndrome, schizophrenia (a mental health condition characterized by symptoms of hallucinations, delusions, disorganized thinking, and difficulty distinguishing reality from imagination), and depression. R2's Service Plan dated May 21, 2025, indicated R2 received the following services; medication administration, medication setup, positioning, bathing, dressing, personal laundry, and meal	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41098	A. BUILDING: _____ B. WING _____	09/17/2025

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01940	Continued From page 29 preparation. R2's Insulin and Blood Glucose Summary dated between September 1, 2025, and September 16, 2025, indicated R2's blood glucose ranged between 120 milligram/deciliter (mg/dL) and 350 mg/dL. R2's service plan lacked to include blood glucose monitoring service. On September 16, 2025, at 2:00 p.m., registered nurse (RN)-B stated R2's blood glucose monitoring service was added later. RN-B also stated they forgot to update R2's service plan. The licensee's Development of Individualized Treatment Management Plan policy dated August 1, 2021, indicated based on the comprehensive nursing assessment, the Registered Nurse (RN) will develop an individualized treatment management plan for each client that needs or requests treatment management services. This plan will be developed with the client and/or client's representative, and this plan will be part of the client's service plan, and the client will be educated on the service plan. Once the treatment management plan has been developed, the RN will develop the client's treatment record with detailed information about the treatments staff will be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GOLDEN TOUCH HEALTH CARE LLC
5012 66TH AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41098

Risk:
License:
Expires on:
CFPM: Sheikh K. Dukuly II
CFPM #: 109724; Exp: 02/11/2028

Inspection Info

Report Number: F1051251105
Inspection Type: Full - Single
Date: 9/15/2025 Time: 10:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT:
AT THE TIME OF INSPECTION, THERE IS NO HANDWASHING SIGN IN THE EMPLOYEE RESTROOM LOCATED IN THE BASEMENT.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, BENARD NYANGENA.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, TETA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL

IN THE KITCHEN AREA, THERE IS A SMOOTH TEXTURE CEILING, VINYL PLANK FLOORS, LAMINATE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, AND A NSF 184 DISHMACHINE.

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 St Cloud District Office inspection report number F1051251105 from 9/15/2025

Kai Yang

Teta

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

GOLDEN TOUCH HEALTH CARE LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1051251105
Inspection Type: Full
Date: 9/15/2025
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No