Electronically Delivered

January 15, 2026

Licensee
Golden Pond Mounds View
7245 Hidden Hollow Court
Mounds View, MN 55112

RE: Project Number(s) SL33572016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33572	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND MOUNDS VIEW	7245 HIDDEN HOLLOW COURT MOUNDS VIEW, MN 55112

(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: SL33572016-0 On December 15, 2025, through December 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 four residents; four receiving services under the 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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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 tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB baseline testing of either a two-step tuberculin skin test (TST) or interferon-gamma release assay (IGRA) blood test for two of two unlicensed personnel ((ULP)-A, ULP-B). 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	0 660		

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0 660	Continued From page 4 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: The licensee's Facility TB Risk Assessment dated June 2, 2025, identified the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on January 8, 2022, to provide direct care to residents. ULP-A's IGRA blood test completed on May 24, 2021, indicated a negative result, however, the TB testing was over 90 days before ULP-A's hire date. ULP-B On December 16, 2025, at 9:03 a.m., the surveyor observed ULP-B assist resident (R1) with medication administration. ULP-B was hired on March 12, 2021, to provide direct care to residents. ULP-B's chest X-ray completed on April 21, 2015, indicated a history of positive tuberculosis skin test. ULP-B's personnel record lacked evidence of documentation for TB testing that included a two-step TST or IGRA; and lacked evidence of any documentation of completed TB treatment in the past. On December 16, 2025, at 1:39 p.m., licensed	0 660		

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0 660	Continued From page 5 assisted living director/registered nurse (LALD/RN)-D stated ULP-A worked at another facility owned by the same company prior to working at this facility so it was an oversight. LALD/RN-D stated they would check for TB test results for ULP-B as they had also been with the company for long time. On December 17, 2025, at 9:34 a.m., in an email, the licensee indicated ULP-B told the licensee they did have a TB blood test completed as it was positive; and that was why the doctor had an X-ray done. On December 17, 2025, at 12:26 p.m., LALD/RN-D stated some staff refuse TB testing and get mad if the licensee requested a two-step TST. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated new staff would have an IGRA blood test or a two-step TST conducted with results documented on the Baseline TB Screening Tool for HCW's; and staff would not be permitted to begin work where they shared the air space with residents until the negative results of the first-step TST was read and documented or a negative IGRA blood test result was received and documented. Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated on page 11, an employee may begin work with patients after a negative TST or IGRA dated within 90 days before hire. Also, on page 13, a health care worker (HCW) with a verbal (undocumented) history of a previous positive TST or IGRA should undergo the same screening procedure as HCW's without previous positive results. If the HCW had documentation of	0 660		

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0 660	Continued From page 6 previous treatment for latent TB infection or active TB disease, then the documentation could be substituted for documentation of previous positive TST or IGRA results. 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 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 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, Physical Environment Inspection Report (PEIR) dated	0 775		

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0 775	Continued From page 7 12-16-25 for the specific violations related the physical environment under Minnesota Statute 144G. 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 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	0 810		

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0 810	Continued From page 8 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 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 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, Physical Environment Inspection Report (PEIR) dated 12-16-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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01500	Continued From page 9 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

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01500	Continued From page 10 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-A, ULP-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 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: ULP-A ULP-A was hired on January 8, 2022, to provide direct care to residents. ULP-A's employee record lacked evidence of the following required topics of annual training in	01500		

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01500	Continued From page 11 2024: - infection control techniques; and - principles of person-centered planning/service delivery. On December 15, 2025, at 2:54 p.m., ULP-A stated staff had completed the annual trainings through the licensee's Residex (electronic medical record and online training) program in 2024. ULP-A confirmed they only had training on topics related to vulnerable adult and Assisted Living Bill of Rights in 2024. ULP-B On December 16, 2025, at 9:03 a.m., the surveyor observed ULP-B assist resident (R1) with medication administration. ULP-B was hired on March 12, 2021, to provide direct care to residents. ULP-B's employee record lacked evidence of the following required topics of annual training in 2024: - reporting maltreatment of vulnerable adults or minors; - infection control techniques; and - principles of person-centered planning/service delivery. On December 17, 2025, at 12:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they would further investigate the annual trainings. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff who provided direct care would complete eight hours of annual training and would include the training elements as required by statue.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33572	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN POND MOUNDS VIEW	7245 HIDDEN HOLLOW COURT MOUNDS VIEW, MN 55112

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01500	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is 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	01530		

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01530	Continued From page 13 paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two unlicensed personnel ((ULP)-A, ULP-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 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: ULP-A ULP-A was hired on January 8, 2022, to provide direct care to residents. ULP-A's Educare (online training) transcript dated December 15, 2025, indicated ULP-A had completed a training course for Mental Illness on June 26, 2022. The training was credited	01530		

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01530	Continued From page 14 forty-five minutes for the course. ULP-A's employee record lacked evidence of additional training for mental illness and de-escalation topics; and did not meet the required two hours of initial training for mental illness and de-escalation topics. ULP-B On December 16, 2025, at 9:03 a.m., the surveyor observed ULP-B assist resident (R1) with medication administration. ULP-B was hired on March 12, 2021, to provide direct care to residents. ULP-B's Staff Training Transcript dated January 1, 2024, to December 16, 2025, indicated ULP-B had completed a training course for Mental Illness - De-Escalation Techniques and Communication on July 2, 2025, in the Clinical LMS (online training). The training was credited forty-five minutes for the course. ULP-B's employee record lacked evidence of additional training for mental illness and de-escalation topics; and did not meet the required two hours of initial training for mental illness and de-escalation topics. On December 15, 2025, at 3:22 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the mental illness training should have been completed in the licensee's Clinical LMS. On December 16, 2025, at 2:04 p.m., LALD/RN-D stated the mental illness training should have been automatically assigned to the staff but they were not sure if they had completed the training. The licensee's Mental Illness & De-escalation	01530		

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01530	Continued From page 15 Training policy dated July 1, 2025, indicated direct care staff would have two hours of initial training on mental illness and de-escalation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01880 SS=F	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 stored securely for all residents with medication management services; and failed to monitor a medication refrigerator to ensure temperatures were maintained according to the manufacturer's instructions for two of two residents (R1, R2) with medications stored in medication refrigerator. 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).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 16 The findings include: STORAGE On December 15, 2025, at 10:14 a.m., during a facility tour with unlicensed personnel (ULP)-A, the surveyor observed R1's room. R1 had unsecured medication on R1's nightstand next to R1's bed. The medication was observed was nystatin Topical Powder. ULP-A stated R1's medications should be locked in the medication cabinet; and R1's nystatin powder was for R1's wound supplies so it could be in R1's room. On December 15, 2025, at 10:14 a.m., during a facility tour with ULP-A, the surveyor observed the medication cabinet under the counter in the kitchen was not locked. The surveyor did not observe any other staff in the room upon entry with ULP-A and there was one resident in a w/c at the kitchen table. ULP-A stated usually the medication cabinet was locked however right now it was medication time. On December 17, 2025, at 11:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1 was currently not using the nystatin powder as the resident was using Interdry dressing cloth (absorbs moisture) and confirmed R1 had not used nystatin powder for a while. LALD/CNS-C stated R1's medications should be stored and locked in the medication cabinet. REFRIGERATOR On December 15, 2025, at 10:14 a.m., during a facility tour with ULP-A, the surveyor observed the licensee's refrigerator used to store medications. The refrigerator had the ability to be locked but the surveyor observed the lock was not latched leaving the medication refrigerator	01880		

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01880	Continued From page 17 unsecured. The surveyor observed the inside of the refrigerator had medications being stored for R1 (Lantus, Trulicity) and R2 (Humira) that required refrigeration. The surveyor observed the thermometer inside of the refrigerator read 30 degrees (°) Fahrenheit (F). On December 15, 2025, at 10:40 a.m., ULP-A stated the refrigerator temperatures should be below 40 ° F. The surveyor asked ULP-A if they had ever contacted the nurse regarding temperatures on the medication refrigerator, ULP-A stated they had never contacted the nurse, and they just record the temperature daily. The licensee's temperature log for the medication refrigerator dated December 2025, indicated instructions to keep temperatures at 40° F or below. The temperatures recorded ranged between 28° F and 32° F. The temperature was not recorded on December 8th through December 10th and again on December 13th. On December 17, 2025, at 11:38 a.m., LALD/CNS-C stated the staff should be documenting the medication refrigerator daily and notify the home coordinators ULP-A and ULP-E. LALD/CNS-C stated they had not been notified when the medication refrigerator was out of range and it would be good to indicate on the log when to call the nurse. LALD/CNS-C stated the medication refrigerator should always be locked. LALD/CNS-C stated they will need to provide more training to staff. The licensee's Medication Storage policy dated August 1, 2021, indicated medications managed by the licensee would be stored and securely locked to prevent diversion of medications. The policy indicated the medications would be stored	01880		

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01880	Continued From page 18 consistently with manufacturer's recommendations. The manufacturer's instructions for Humira injection revised February 2021, indicated Humira must be refrigerated at 36° F to 46° F and not to freeze. The instructions indicated not to use if frozen even if it had been thawed. The manufacturer's instructions for Lantus Solostar pen revised November 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for Trulicity injection revised June 2025, indicated to store in the refrigerator at 36° F to 46° F and not to use Trulicity if it had been frozen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Golden Pond Mounds view
7245 HIDDEN HOLLOW COURT
Mounds View, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 33572

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1025251232
Inspection Type: Full - Single
Date: 12/15/2025 Time: 12:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: Course certificate posted - post the CFPM certificate, or a copy with address written on it if the original is posted at another facility within the permitted distance.
Comply By: 12/15/2025 Originally Issued On: 12/15/2025

Food & Beverage General Comment

Test kit for chlorine and quat available, discussed santizing food contact surfaces if dish washer is not operating
Food TMD available
Min/max TMD for dish machine available
Discussed health/hygiene, cookware, food contact surfaces, testing dish machine, recalls, allergies, pest control, date marking

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1025251232 from 12/15/2025

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Golden Pond Mounds view
Mounds View
County/Group: Ramsey County

Inspection Info

Report Number: F1025251232
Inspection Type: Full
Date: 12/15/2025
Time: 12:00 PM

Food Temperature: Product/Item/Unit: Sour cream**; Temperature Process:** Cold holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Freezer**; Temperature Process:** Frozen
Location: Garage at Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33572016-0	**Date:** 12/16/2025
Facility Name: GOLDEN POND MOUNDS VIEW	
Facility Address: 7245 HIDDEN HOLLOW COURT, Mounds view, MN 55112	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The exit path from the rear of the facility was blocked with snow accumulation.

3. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired were defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: The fire suppression system was disabled to the facility. licensed assisted living director/registered nurse (LALD/RN)-D stated they had a sprinkler head break and flood the facility. After that event a section of the riser was removed to disable the system. The facility was still protected with interconnected smoke alarms and egress compliant windows.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments:

The evacuation plans direct exiting through the garage. Exiting through an area of higher hazard is not permitted.

The deck has an exit sign. The deck is not a designated exit on the evacuation plans.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.

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

   Comments: The licensee's fire drill log indicated no fire drills were performed with the "PM" shift.