



Protecting, Maintaining and Improving the Health of All Minnesotans

June 8, 2022

Administrator
Golden Pond BP
10251 Yates Drive
Brooklyn Park, MN 55443

RE: Project Number(s) SL36447015

Dear Administrator:

On May 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 6, 2021, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2022

Administrator
Golden Pond BP
10251 Yates Drive
Brooklyn Park, MN 55443

RE: Project Number(s) SL36447015

Dear Administrator:

On January 6, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 6, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 6, 2021, found not corrected at the time of the January 7, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144G.42, subd. 10 - \$500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 6, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to

Health.HRD.Appeals@state.mn.us.

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

pmb

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL36447015 On January 6, 2022 and January 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 6, 2021. At the time of the survey, there was one active resident receiving services under the Assisted Living license. As a result of the revisit the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP			STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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	
{0 680}	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect the one current resident receiving services under the assisted living license, staff and any visitors to the facility. 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	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
{0 680}	Continued From page 2 resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Upon entrance into the facility on January 6, 2022, at approximately 10:14 a.m., the surveyor observed information regarding the licensee's emergency preparedness plan posted near the main entry of the facility. The signage diagramed the location of emergency exits in the facility, location of fire extinguishers, designated meeting place and other emergency information. The same signage was also posted near the garage side entry of the facility. The licensee later provided the surveyor with the written emergency preparedness plan for review. During a video conference on January 6, 2022, at approximately 10:50 a.m., the owner/registered nurse (RN)-A acknowledged the licensee had received a citation for the emergency plan and indicated they felt it had been corrected. The licensee's EP plan lacked the following: -current, all-hazards approach facility assessment; -description of population served by the licensee; and -process for EP cooperation with state and local EP officials/organizations. -development of all policies/procedures, based on the assessment and additional policies for: -subsistence needs for staff and residents during emergency situations; -tracking residents and staff; -potential evacuation;	{0 680}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
{0 680}	Continued From page 3 -sheltering in place; -handling and safekeeping of medical documents; and -handling and use of volunteers. -arrangements with other facilities (including sister facilities or any outside facilities or agencies), and -a communication plan that included: -primary and alternate means for communication; -methods for sharing information. -an EP training and testing program that addressed: -the training program for staff (including documentation of training provided); and -annual EP training testing requirements for the facility. During a previous interview on October 7, 2021, at approximately 11:52 a.m., RN-A acknowledged the plan lacked the required components. RN-A verified there were no written vulnerability assessments of the hazards or the population the licensee served. The licensee's "9.01 Emergency Preparedness Plan - Appendix Z Compliance" policy dated June 1, 2021, indicated the licensees' emergency preparedness plan would include all required elements of Appendix Z. The policy indicated the plan is based on assisted living-based and community based risk assessments, utilizing an all-hazards approach; it included a communications plan, training, and exercises and drills. Also, the policy indicated key elements of the plan included four primary components: 1. Risk and assessment and planning; 2. Policies and procedures; 3. A communication plan; and 4. Staff training and exercises/drills.	{0 680}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
{0 680}	Continued From page 4 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 680}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No additional action is required.	{0 790}		
{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) employee 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,	{0 810}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/07/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP			STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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	
{0 810}	Continued From page 5 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees 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 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. This MN Requirement is not met as evidenced by: No additional action is required.	{0 810}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 22, 2021

Administrator
Golden Pond BP
10251 Yates Drive
Brooklyn Park, MN 55443

RE: Project Number(s) SL36447015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 6, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, subs. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general
reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration
requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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 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: Project # SL36447015 On October 5, 2021, through October 7, 2021, surveyors of this Department's staff visited the above Assisted Living licensed provider, and the following correction orders are issued. At the time of the survey, there was one (1) resident receiving services under the assisted living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 430	Continued From page 2 R1 was admitted for services on February 15, 2021. R1 continued receiving assisted living services when the licensee transitioned to providing assisted living services under the new 144G statutes, beginning August 1, 2021. On October 5, 2021, at approximately 2:20 p.m. R1 was observed seated in a wheel chair in his room. R1 was appropriately dressed, was able to move freely about the room in his wheelchair, and appeared free of any discomfort or distress. R1's Service Plan Addendum to Contract Agreement dated as printed October 6, 2021, indicated services included, but were not limited to, basic services (bed making, housekeeping, linen changes, meal assistance), activity assistance and behavior monitoring. R1's record lacked a uniform checklist disclosure of services (UDALSA) to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract On October 6, 2021, at approximately 10:19 a.m. owner/registered nurse (RN)-A stated the resident was admitted last February and continued receiving services through the new licensure. RN-A acknowledged R1 did not have a UDALSA as part of his record, adding the resident has a guardian who would need to sign the client's	0 430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 430	Continued From page 3 paperwork. Prior to the survey exit, the licensee obtained written acknowledgement the guardian received the UDALSA dated October 6, 2021. The licensee's 1.04 Uniform Disclosure of Assisted Living services & Amenities (UDALSA) policy dated August 1, 2021, indicated the licensee would provide a UDALSA to prospective residents prior to signing an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 470	Continued From page 4 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect the licensee's one current resident, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of five (5) residents and had a current census of one (1) resident. During the entrance conference on October 5, 2021, at approximately 11:35 a.m. owner/registered nurse (RN)-A and RN-B acknowledged the lack of a written staffing plan.	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 470	Continued From page 5 In addition, a staff schedule was not posted. RN-B stated the concept was "pretty self-explanatory" and it was something they would work on. RN-B said they were a small setting, having only one resident, but a plan would be based on resident needs as identified on the care plan and resident acuity. The licensee's 4.06 Staffing & Scheduling policy dated June 10, 2021, indicated the licensee will assure qualified employees will be scheduled to meet operations requirements and the needs of the residents. The policy directed the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The policy indicated the staffing levels would be based on resident's needs, acuity level, ability of staff to meet needs timely, and also be based on staff experience, training and competency. Additionally, the policy indicated the daily work schedule for direct care staff showing work shifts and days and hours worked, would be posted at beginning of each work shift in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 550	Continued From page 6 are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post information related to the grievance procedure, resident advocacy information, as well as information for reporting suspected maltreatment. This had the potential to affect the one, current resident receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: The licensee lacked postings in conspicuous location and disclosure of resident advocacy to include: -a posting with all required content of the licensee's grievance procedure to include the name and email contact information for the individuals who are responsible for handling grievances; -contact information for the Office of Ombudsman	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 550	Continued From page 7 for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On October 5, 2021, upon entrance into the facility beginning at approximately 10:30 a.m., observations revealed the licensee lacked any posting of the above required content. During a tour of the facility on October 5, 2021, at approximately 3:37 p.m. with unlicensed personnel (ULP)-A and RN-B and in presence of the surveyors, there lacked any required postings as described above. ULP-A verified there was no contact information posted for any Ombudsman office, or number for the MAARC to report incidents or potential abuse. ULP-A thought they had all the required information posted at the front entry and door, but verified they did not. Policies regarding required facility postings and disclosure of contact information for resident support and abuse reporting were requested, but none were provided. The licensee's "Complaint Policy and Procedure" dated August 1, 2021, lacked information regarding posting of the facility's grievance procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 580	Continued From page 8	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect the one (1) current resident, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On October 5, 2021, at approximately 12:33 p.m. during the entrance conference with	0 580		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 580	Continued From page 9 owner/registered nurse (RN)-A and RN-B, a request was made to review documentation of the licensee's quality management activities. RN-A went on to explain they reviewed and discussed "many things," such as COVID, lack of PPE (personal protective equipment), issues regarding fire alarms, that affected us here at this and other locations. RN-A acknowledged a lack of any documentation of quality management meetings or activities. RN-A also stated that although they had a policy regarding quality, there was no current, formal plan. RN-A again verified the lack of documentation to meet this requirement. The licensee's 2.31 Quality Management Project policy dated August 1, 2021, indicated the licensee will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The policy further indicated quality management documentation should be made available, upon request, to the Minnesota Department of Health surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 650	Continued From page 10 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual performance reviews were completed for two of four employees, unlicensed personnel (ULP)-A and ULP-B with employee records reviewed. In addition, the licensee failed to ensure a current job description was included as part of the record for one of four employees (registered nurse (RN)-B) with employee records reviewed. 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	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 650	Continued From page 11 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: Unlicensed personnel (ULP)-A and ULP-B ULP-A had a hire date May 20, 2010 and ULP-B had a hire date November 28, 2017. Both employees' records lacked evidence of annual performance reviews. On October 5, 2021, at approximately 2:20 p.m. ULP-A was observed interacting with R1. ULP-A first knocked, received permission, then entered resident R1's room. ULP-A asked if R1 needed or wanted anything, but R1 declined. Registered nurse (RN)-B RN-B's employee record was reviewed, and lacked evidence of a current job description. Review of records and assessments indicated RN-B actively provided assisted living services to the licensee's current resident. On October 6, 2021, at 1:30 p.m. RN-A verified ULP-A and ULP-B's records lacked evidence of annual performance reviews. Also, RN-A confirmed RN-B's employee record lacked evidence of a current job description. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated the licensee will keep an employee record for all paid employees. The policy directed records for each person would include, among a list of other items: current	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 650	Continued From page 12 signed, job description; and documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC). The licensee failed to complete a facility risk assessment. In addition, the licensee failed to ensure employee TB history and symptom	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 660	Continued From page 13 screenings were completed upon hire for two of two employees (unlicensed personnel (ULP)-A and ULP-B); and ensure initial TB related staff training and education was completed for four of four employees (registered nurse (RN)-B, ULP-A, ULP-B, ULP-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 5, 2021, at approximately 12:21 p.m. the surveyor requested the licensee's facility TB risk assessment. On October 5, 2021, at approximately 3:24 p.m. owner/registered nurse (RN)-A stated the licensee had a TB infection control program, policies and procedures; and stated each employee was individually screened for TB at the time of hire. RN-A said each employee completed a TB history and symptom screen. On October 6, 2021, at approximately 1:30 p.m. a request was made to review the licensee's written TB infection control program that included: - documentation of supervisory responsibility for the TB infection control program; - written infection control policies and procedures and education for handling infectious TB residents; - the specific content of TB training for healthcare	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 660	Continued From page 14 workers including basic information about TB pathogenesis and transmission, handling a potentially infectious TB resident, and the employee's role in the TB infection control program. LACK OF TB FACILITY RISK ASSESSMENT The licensee's TB infection control binder revealed a blank TB facility risk assessment form. On October 6, 2021, at about 1:33 p.m. RN-A expressed some confusion about what the TB facility risk assessment was, and what it was used for, and acknowledged their form was not completed. EMPLOYEE TB EDUCATION/TRAINING AND TB SCREENING ULP-A, ULP-B, ULP-C and RN-B's employee records lacked evidence of required TB training at the time of hire to include content on basic information related to: * TB pathogenesis and transmission; * Signs and symptoms of active TB disease; and * The licensee's infection control plan (how to implement the licensee's early recognition, isolation, and referral procedures) and especially any sections that employees were responsible for implementing. ULP-A, ULP-B and ULP-C's employee records lacked evidence of a two-step, tuberculin skin test (TST) or other accepted TB test, such as an IGRA (interferon-gamma release assay) blood test or a negative chest x-ray. On October 6, 2021, at approximately 1:40 p.m.	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 660	Continued From page 15 RN-A confirmed ULP-A, ULP-B and ULP-C's employee records lacked evidence of TB testing or chest x-rays. RN-A stated TB training was provided to employees at hire, but verified the lack of documentation in the employees' records. Prior to the survey exit, the licensee completed a facility TB risk assessment. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated the licensee will establish and maintain a comprehensive TB infection control program according to the most current TB guidelines issued by the CDC. The policy indicated the facility will maintain a current community TB risk assessment. Further, staff will be educated regarding TB at time of hire and content of training should be appropriate to the job responsibility and educations/professional background of the employee, including the topics identified above. In addition, staff will be screened for active signs of TB using the screening tool, having an IGRA blood test or a two-step Mantoux conducted with results documented on the TB screening tool and kept in each employee's file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated health care workers (HCW) may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 660	Continued From page 16 screening should be documented in the employee's record. TB training is required at time of hire for all HCWs. The content of training should be appropriate to the job responsibilities and educational/professional background of the HCW. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 680	Continued From page 17 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect the one current resident receiving services under the assisted living license, as well any staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During observations upon entrance to the facility on October 5, 2021, at approximately 10:30 a.m. there was no signage posted or information regarding the licensee's emergency preparedness plan. Emergency exits were posted and there was a wall near the entry which displayed several informational posters related to infection control; however, there was no information regarding an emergency preparedness plan posted near the facility entrance. During the entrance conference on October 5, 2021, at approximately 10:30 a.m. a request was	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 680	Continued From page 18 made to view the licensee's emergency preparedness plan. On October 5, 2021, at approximately 12:49 p.m. owner/registered nurse (RN)-A stated they felt they "did have an emergency plan," but acknowledged there was no document that included the required content "all in one place." RN-A could not locate a facility vulnerability hazard assessment or a description of the resident population, but they had a number of the required policies. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 680	Continued From page 19 During a subsequent interview on October 6, 2021, at approximately 1:26 p.m. RN-A verified there was no completed emergency preparedness plan "with all that was required." RN-A acknowledged this was something they would have to address and work on. The licensee's "9.01 Emergency Preparedness Plan - Appendix Z Compliance" policy dated June 1, 2021, indicated the licensees' emergency preparedness plan would include all required elements of appendix Z. The policy indicated the plan is based on our assisted living-based and community based risk assessments, utilizing an all-hazards approach; it included a communications plan, training, and exercises and drills. Also, the policy indicated key elements of the plan included four primary components: 1. Risk and assessment and planning; 2. Policies and procedures; 3. A communication plan; and 4. Staff training and exercises/drills No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 790	Continued From page 20 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure installation and maintenance of portable fire extinguishers onsite. This had the potential to directly affect the one current resident, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the facility tour on October 5, 2021, at approximately 2:00 p.m. the surveyor observed all portable fire extinguishers were missing from their mounting brackets. There were brackets located by the kitchen sink, dining table, entrance to bedroom hallway, and next to basement mechanical room. The owner/registered nurse (RN)-A, stated all the extinguishers had been picked up that day for inspection and testing. RN-A stated they would be reinstalled the next day or by the end of the week. On October 5, 2021, at approximately 2:15 p.m. unlicensed personnel (ULP)-A stated all of the extinguishers had been picked up that day for	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 790	Continued From page 21 inspection and testing by the fire protection company. ULP-A said they were expected to be reinstalled the next day or by week's end. A policy related to portable fire extinguishers was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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) employee 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) Employees 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	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 810	Continued From page 22 training shall be made available to residents at least once per year. (f) 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of policy, schedule, and a log of staff or resident training for fire safety and evacuation procedures. This had the potential to affect the one (1) current resident, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On October 5, 2021, at approximately 2:00 p.m. owner/registered nurse (RN)-A confirmed the licensee had not fully developed a plan and schedule for required training and evacuation drills. A policy related to a plan for required training of residents, training of employees, and evacuation drills was not available at the time of survey.	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 810	Continued From page 23 On October 5, 2021, at approximately 3:28 p.m. RN-A emailed the policy to the surveyor. The licensee's policy indicated it was an outline for policy and procedures, but had not been developed specifically for this location and had not been implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 900	Continued From page 24 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for the licensee's one current resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted for services on February 15, 2021. R1 received services as the licensee transitioned into the new assisted living licensure beginning August 1, 2021. R1's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 900	Continued From page 25 contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On October 5, 2021, at approximately 12:06 p.m. owner/registered nurse (RN)-A stated they have a "new model admission agreement" for our residents, but "we don't have this yet signed" by our patients. RN-A stated their attorney was reviewing the current, new documents they received from their provider organization. RN-A said R1's most recent contract was dated June 2021. RN-A also noted the difficulty to complete the contract requirements for R1, due the the resident's diagnoses and the fact R1's affairs	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
0 900	Continued From page 26 were handled by the resident's guardian. On October 5, 2021, at approximately 2:20 p.m. ULP-A was observed interacting with resident R1. ULP-A first knocked, received permission, then entered R1's room. ULP-A asked if R1 needed or wanted anything, but R1 declined. R1's Service Plan Agreement dated and printed October 6, 2021, indicated services included assistance with socialization, cares, ambulation/exercise and behavior monitoring. During the survey, RN-A contacted R1's guardian and obtained signed acknowledgement of documents received, including the admission and lease agreement, dated October 6, 2021. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated when a prospective resident decides to move into the facility, a signed assisted living contracted [sic] signed and received by the facility. The policy was unclear to indicate the contract/agreement needed to be signed prior to the start of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01370 SS=D	144G.61 Subd. 2 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	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01370	Continued From page 27 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 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 the registered nurse	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01370	Continued From page 28 (RN) trained and competency tested one of three unlicensed personnel (ULP-C) in all required skill areas with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on December 22, 2020, to provide direct care services to the licensee's residents. ULP-C's employee training record lacked evidence ULP-C had successful completion of practical skills evaluation as required for training in the following areas: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums and oral prosthetic devices; -care and use of hearing aides; -dressing and assisting with toileting; and -standby assistance techniques and how to perform them. On October 6, 2021, at approximately 1:30 p.m. RN-B stated they were aware of the required training topics for ULP, and competencies were supervised but perhaps "not documented." RN-B verified ULP-C's record lacked documentation of competency evaluation. The licensee's 5.02 Competency Training	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01370	Continued From page 29 Evaluations policy dated August 1, 2021, indicated prior to the delegation of services, the RN must make certain the ULP is trained in the proper methods to perform tasks or procedures for each resident and are able to demonstration the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluation of ULP would include, among others, the skills listed above. Further, the education, training and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01380 SS=D	144G.61 Subd. 2 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 (7) administering medications or treatments as required.	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01380	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested one of three unlicensed personnel (ULP-C) in all required skill areas with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on December 22, 2020, to provide direct care services to the licensee's residents. ULP-C's employee training record, intended as evidence of an evaluation by the registered nurse (RN), lacked evidence that ULP-C had successful completion of practical skills evaluation for training in the following areas: -reading and recording temperature, pulse, and respirations of the client; and -range of motioning and positioning. On October 6, 2021, at approximately 1:30 p.m. RN-B stated they were aware of the required training topics for ULP, and competencies were supervised but perhaps not documented. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated prior to the delegation of services, the	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01380	Continued From page 31 RN must make certain the ULP is trained in the proper methods to perform tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluation of ULP would include, among others, the skills listed above. Further, the education, training and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01470	Continued From page 32 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure one of four employees, registered nurse (RN)-B received orientation to	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01470	Continued From page 33 144G licensing requirements with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-B was hired on August 25, 2020, to provide direct care services to the licensee's residents and supervision of staff. RN-B's employee training record lacked evidence that RN-B was oriented to 144G licensing requirements in the following areas: -an overview of 144G statutes; -introduction and review of all the provider's policies and procedures related to the provision of assisted living services under 144G statutes; and -review of person-centered planning and care. On October 6, 2021, at approximately 1:30 p.m. owner/registered nurse (RN)-A and RN-B stated they were aware of the required training topics, although they were unable to provide requested documentation. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated training will be documented, and will include an overview of 144G statutes; introduction and review of all the provider's policies and procedures related to the provision of	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01470	Continued From page 34 assisted living services under 144G statutes; review of person-centered planning and care. The policy also indicated all staff must complete an orientation to licensing requirements before providing assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-C and registered nurse (RN)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
01490	Continued From page 35 The licensee had a comprehensive home care license prior to August 1, 2021, at which time they obtained an Assisted Living License. ULP-A was hired May 20, 2010. ULP-A's employee file lacked evidence of completing any dementia care training. ULP-B was hired November 27, 2017. ULP-B's employee file lacked evidence of completing any dementia care training. ULP-C was hired December 22, 2020. ULP-C's employee file lacked evidence of completing any dementia care training. Registered nurse (RN)-B had a hire date of August 25, 2020. RN-B's employee file lacked evidence of completing any dementia care training. On October 6, 2021, at approximately 1:30 p.m. owner/RN-A and RN-B stated they were aware of the required training and specific topics for dementia, but were unable to provide evidence staff had received the required training for all employees listed above. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
03090	Continued From page 36	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8. Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect the one current resident, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 5, 2021, at approximately 10:30 a.m. surveyors entered the facility and at the main entry way there was no signage to notify visitors of electronic monitoring. During a subsequent tour of the facility at 3:37 p.m., unlicensed personnel (ULP)-A stated "we don't have any	03090		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN POND BP		STREET ADDRESS, CITY, STATE, ZIP CODE 10251 YATES DRIVE BROOKLYN PARK, MN 55443		
(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
03090	Continued From page 37 monitoring." ULP-A verified there was no posted signage regarding the potential for electronic monitoring. Prior to survey exit on October 6, 2021, the licensee posted a sign regarding electronic monitoring near the main entry that displayed the statutory language. The licensee's 2.15 Electronic Monitoring policy dated August 1, 2021, indicated the licensee will support the use of electronic monitoring by our residents and representatives. The policy directed under #1 of the procedure: signs are install at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to records persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Type: Full
Date: 10/05/21
Time: 12:00:00
Report: 8087211292

Food and Beverage Establishment Inspection Report

Page 1

Location:

Golden Pond Bp
10251 Yates Drive
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0038499
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632085247
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air

Temperature: 36 Degrees Fahrenheit - Location: OUTDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: MILK

Temperature: 36 Degrees Fahrenheit - Location: OUTDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Air

Temperature: 0 Degrees Fahrenheit - Location: OUTDOOR STAND-UP FREEZER

Violation Issued: No

Process/Item: Ambient Air

Temperature: 38 Degrees Fahrenheit - Location: INDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: RICE

Temperature: 39 Degrees Fahrenheit - Location: INDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: CHICKEN

Temperature: 38 Degrees Fahrenheit - Location: INDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: HOT DOG

Temperature: 39 Degrees Fahrenheit - Location: INDOOR STAND-UP REFRIGERATOR

Violation Issued: No

Type: Full
Date: 10/05/21
Time: 12:00:00
Report: 8087211292
Golden Pond Bp

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Ambient Air

Temperature: 0 Degrees Fahrenheit - Location: INDOOR STAND-UP FREEZER

Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF REGISTERED NURSE TRACY POUTI.

KENMORE BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 126 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE RESIDENTIAL KITCHEN.

INSPECTION REPORT EMAILED TO BRUCE MELCHERT.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087211292 of 10/05/21.

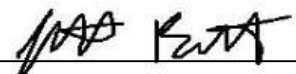
Certified Food Protection Manager: NA

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

TRACY POUTI
REGISTERED NURSE

Signed:  _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us

Report #: 8087211292

Food Establishment Inspection Report



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN

No. of RF/PHI Categories Out

0

Date 10/05/21

No. of Repeat RF/PHI Categories Out

0

Time In 12:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Golden Pond Bp

Address

10251 Yates Drive

City/State

Brooklyn Park, MN

Zip Code

55443

Telephone

7632085247

License/Permit #
0038499

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS R

Supervision

1	IN	OUT	PIC knowledgeable; duties & oversight		
2	IN	OUT	Certified food protection manager, duties		

Employee Health

3	IN	OUT	Mgmt/Staff; knowledge, responsibilities & reporting		
4	IN	OUT	Proper use of reporting, restriction & exclusion		
5	IN	OUT	Procedures for responding to vomiting & diarrheal events		

Good Hygienic Practices

6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth		

Preventing Contamination by Hands

8	IN	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A	No bare hand contact with RTE foods or pre-approved alternate procedure properly followed		
10	IN	OUT		Adequate handwashing sinks supplied/accessible		

Approved Source

11	IN	OUT		Food obtained from approved source		
12	IN	OUT	N/A	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A	Required records available; shellstock tags, parasite destruction		

Protection from Contamination

15	IN	OUT	N/A	Food separated and protected		
16	IN	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	IN	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status

COS R

Time/Temperature Control for Safety

18	IN	OUT	N/A	N/O	Proper cooking time & temperature		
19	IN	OUT	N/A	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	N/O	Proper cooling time & temperature		
21	IN	OUT	N/A	N/O	Proper hot holding temperatures		
22	IN	OUT	N/A		Proper cold holding temperatures		
23	IN	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	N/A	N/O	Time as a public health control: procedures & records		

Consumer Advisory

25	IN	OUT	N/A		Consumer advisory provided for raw/undercooked food		
----	----	-----	-----	--	---	--	--

Highly Susceptible Populations

26	IN	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
----	----	-----	-----	--	--	--	--

Food and Color Additives and Toxic Substances

27	IN	OUT	N/A		Food additives: approved & properly used		
28	IN	OUT			Toxic substances properly identified, stored, & used		

Conformance with Approved Procedures

29	IN	OUT	N/A		Compliance with variance/specialized process/HACCP		
----	----	-----	-----	--	--	--	--

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

COS R

Safe Food and Water

30	IN	OUT	N/A	Pasteurized eggs used where required		
31				Water & ice obtained from an approved source		
32	IN	OUT	N/A	Variance obtained for specialized processing methods		

Food Temperature Control

33				Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	Approved thawing methods used		
36				Thermometers provided & accurate		

Food Identification

37				Food properly labeled; original container		
----	--	--	--	---	--	--

Prevention of Food Contamination

38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

Proper Use of Utensils

43				In-use utensils: properly stored		
44				Utensils, equipment & linens: properly stored, dried, & handled		
45				Single-use/single service articles: properly stored & used		
46				Gloves used properly		

Utensil Equipment and Vending

47				Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48				Warewashing facilities: installed, maintained, & used; test strips		
49				Non-food contact surfaces clean		

Physical Facilities

50				Hot & cold water available; adequate pressure		
51				Plumbing installed; proper backflow devices		
52				Sewage & waste water properly disposed		
53				Toilet facilities: properly constructed, supplied, & cleaned		
54				Garbage & refuse properly disposed; facilities maintained		
55				Physical facilities installed, maintained, & clean		
56				Adequate ventilation & lighting; designated areas used		
57				Compliance with MCIAA		
58				Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature)

Date: 10/08/21

Inspector (Signature)