Electronically Delivered

August 20, 2026

Licensee
Golden Oaks Home Care LLC
7100 Maryland Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL35868016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 28, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35868	A. BUILDING: _____ B. WING _____	07/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN OAKS HOME CARE LLC	7100 MARYLAND AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35868016-0 On July 27, 2026, through July 28, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review as required. 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	0 470		

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0 470	Continued From page 2 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 July 28, 2026, at 9:09 a.m., during a facility tour, the surveyor observed an undated, laminated, daily staffing schedule posted titled Staffing Plan - Schedule. The schedule included a table with the following information: - first row listed the days of the week, Monday through Sunday; - second row indicated morning shift was an eight-hour shift from 7:00 a.m. to 3:00 p.m., and there would be an unlicensed personnel (ULP) present; - third row indicated an evening shift was an eight-hour shift from 3:00 p.m. to 11:00 p.m., and there would be a ULP present; and - fourth row indicated night shift was and eight-hour shift from 11:00 p.m. to 7:00 am and there would be a ULP present. Below the table showed the following information: - licensed assisted living director/registered nurse (LALD/RN)-D was available Monday through Friday from 9:00 a.m. to 5:00 p.m. - clinical nurse supervisor (CNS)-C was available on Monday, Wednesday, and Friday from 9:00 a.m. to 5:00 p.m.; - on call 24/7 nursing and administration availability and listed a phone number to contact the individuals listed above; - "# of hours/shift- 8 Hours Second Staff Mon. -Fri: 10 am-6pm"; - "Staff indicated on the day: If more than one, the number will be indicated". The schedule did not indicate on any of the days a second staff member would present. The staff	0 470		

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0 470	Continued From page 3 schedule was not dated with the dates that Monday through Sunday corresponded to. The document did not meet the requirements of a staff schedule. On July 27, 2026, at 11:14 a.m., during the entrance conference, CNS-C stated a person's name was not needed on the daily staff schedule and they usually had one ULP that worked each shift which was reflected on the schedule. CNS-C stated the schedule normally did not change and they did not want to print and post the same schedule multiple times. CNS-C stated the schedule was not dated unless there was a change made to the schedule. On July 28, 2026, at approximately 1:10 p.m., during an interview with LALD/RN-D and CNS-C, LALD-D stated the licensee did not usually have a second ULP during the day unless it was needed for appointments or activities. LALD/RN-D stated if there were two ULP scheduled, one ULP would be out in the community with the residents and one ULP would be at the facility. CNS-C stated they used ULP on the daily staff schedule verses an employee's name so they would not have to remove a name if there was a change to the schedule. CNS-C stated if there was a second ULP they would put the number two in parentheses in front of ULP. CNS-C stated the daily staff schedule was created based on the resident assessments and resident's needs. LALD-D stated they worked at the facility on Monday, Wednesday, and Fridays and the schedule showed their availability not necessarily when they were at the facility. CNS-C stated the nurses' hours listed on the daily staff schedule were the times the nurses were available. The Minnesota Administrative Rules 4659.0180	0 470		

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0 470	Continued From page 4 subpart 4. Dated August 11, 2021, read, "A. The clinical nurse supervisor must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. B. The daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure." The 4.06 Staffing & Scheduling dated August 1, 2023, indicated the CNS would develop a 24-hour daily staffing schedule that would identify: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and - direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630		

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0 630	Continued From page 5 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 12, 2025, and began receiving assisted living services. R1's diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings, including manic episodes and depressive episodes) with psychosis, major depressive disorder, mild intellectual disabilities, and post-traumatic stress disorder.	0 630		

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0 630	Continued From page 6 R1's Service Plan (Waiver) - Addendum to Contract signed June 5, 2026, indicated R1 received assistance with appointments, bathing reminders, behavior management, housekeeping, medication management which included medication administration, shopping, and transportation. R1's IAPP dated June 5, 2026, indicated R1 was at risk to be abused by others and R1 had a history of physical aggression towards males, yelling at staff, hearing and seeing things that were not observed by others, and experienced paranoia and aggression. R1's IAPP included statement of specific measures to be taken to minimize the risk of abuse to R1 and decrease behaviors. Although R1's IAPP identified a history of aggression towards males and yelling at staff, R1's IAPP failed to assess their risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R2's diagnoses included psychosis, mood disorder, seizures, and schizoaffective disorder (a mental health disorder that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms such as depression and mania). R2's Service Plan (Waiver) - Addendum to Contract July 11, 2026, indicated R2 received assistance with activities, bathing, behavior	0 630		

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0 630	Continued From page 7 management, medication administration, and shopping. R2's IAPP dated July 11, 2026, indicated R2 was at risk of being abused by others, R2 had a history of suicidal thoughts, and experienced hallucinations, paranoia, and anxiety. R2's IAPP included statement of specific measures to be taken to minimize the risk of abuse to R2 and decrease behaviors. R2's IAPP lacked an individualized review or assessment of R2's risk of abusing other individuals. R3 R3 was admitted to the licensee on July 1, 2022, and began receiving assisted living services. R3's diagnoses included schizoaffective disorder, acute hypoxemic respiratory failure, and renal failure. R3's Service Plan (Waiver) - Addendum to Contract signed August 14, 2022, indicated R3 received assistance with behavior management, housekeeping, meals, and monitoring of their oxygen saturations and temperatures. R3's IAPP dated July 24, 2026, indicated R3 was at risk of being abused by others, and R3 had a history of verbal aggression and was easily agitated, and experienced paranoia, self-isolation, and anxiety. R3's IAPP included statement of specific measures to be taken to minimize the risk of abuse to R3 and decrease behaviors. R3's IAPP lacked an individualized review or assessment of R3's risk of abusing other individuals. On July 28, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-C stated in Residex (a	0 630		

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0 630	Continued From page 8 documenting software) assessments, there were questions located under the safety section that addressed if a resident was or was not at risk to abuse others. CNS-C stated the questions were not "selected" (addressed) within the assessment. CNS-C stated they believed R1, R2, and R3's IAPP lacked the information listed above because they were still learning how to use Residex's software and the software's advancements. The licensee's 6.05 Individual Abuse Prevention Plan dated July 1, 2026, indicated the licensee shall develop, implement, and maintain and IAPP for each resident receiving assisted living services as part of the resident's assessment and person-centered service plan. The IAPP shall be reviewed upon admission, whenever there was a significant change in the resident's condition or circumstances, and at least annually as part of the service plan review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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;	0 680		

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0 680	Continued From page 9 (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 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 interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP binder titled [the licensee's name] Emergency Preparedness Survey Binder Appendix Z last reviewed June 1,	0 680		

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0 680	Continued From page 10 2026, included a table which included information of company names, locations, and phone numbers. The table had a section which included sewage disposal and waste disposal however, the sections were filled in with "N/A" (not applicable). The lacked evidence of the following required content: - strategies for addressing facility and community-based risks which included staffing surges and shortages; and - policy and procedure related to sewage and waste. On July 28, 2026, at 12:55 p.m., clinical nurse supervisor (CNS)-C stated the licensee customized an EPP template that was created in 2022 and was purchased from another company. CNS-C stated they did not fill in the provision correctly that discussed sewage and waste. On July 28, 2026, at 1:10 p.m., during an interview with licensed assisted living director/registered nurse (LALD/RN)-D and CNS-C, CNS-C stated they were aware sewage and waste needed to be included in the EPP and the licensee did have a provision related to sewage and waste in the EPP, however they did not fill the template in correctly. CNS-C stated they were unable to find any information in the EPP related to staffing surges or shortages. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations	0 680		

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0 680	Continued From page 11 Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. The licensee's 1.05 Handling of Emergencies and use of Emergency Services dated August 1, 2021, indicated the licensee must have a disaster planning and emergency preparedness plan. The EPP shall have a provision of subsistence needs for residents and staff, whether they evacuate or shelter in place, including, but not limited to sewage and waste disposal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written contract with the required content for current residents and any potential future residents of the assisted living	0 910		

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GOLDEN OAKS HOME CARE LLC	7100 MARYLAND AVENUE NORTH BROOKLYN PARK, MN 55428

(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
0 910	Continued From page 12 facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee Health Facility identification number (HFID#) was 35868. The licensee's Assisted Living Contract lacked the following required content: - in a conspicuous place and manner on the contract the health facility HFID# of the facility. On July 28, 2026, at 1:10 p.m., during an interview with licensed assisted living director/registered nurse (LALD/RN)-D and clinical nurse supervisor (CNS)-C, CNS-C verified the licensee's blank contract lacked the licensee's HFID#. LALD/RN-D stated the licensee contract had an area for the license number. CNS-C stated the blank contract was used by all residents. The surveyor informed CNS-C and LALD/RN-D that some of the resident's contracts differed slightly from the blank contract as the section for indemnification was removed. The surveyor inquired about why the HFID# was not located on the contract. CNS-C stated they did not receive the newly revised contract from the consulting agency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35868	A. BUILDING: _____ B. WING _____	07/28/2026

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GOLDEN OAKS HOME CARE LLC	7100 MARYLAND AVENUE NORTH BROOKLYN PARK, MN 55428

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0 910	Continued From page 13 (21) days	0 910		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all refrigerated medication in a securely locked location. 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 July 27, 2026, at 9:10 a.m., during a facility tour, the surveyor observed an unlocked medication refrigerator located in the lower-level common area of the facility. The refrigerator held the following medications: - one Abilify Maintena 400 milligram (mg) injection 400 mg for R2; - 16 NovoLog FlexPen for R4; - nine Lantus SoloStar pens for R4; and - one Ozempic 2mg/3ml pen with a needle located in the box for R4.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35868	A. BUILDING: _____ B. WING _____	07/28/2026

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GOLDEN OAKS HOME CARE LLC	7100 MARYLAND AVENUE NORTH BROOKLYN PARK, MN 55428

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01880	Continued From page 14 On July 27, 2026, at 9:43 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated, "it's not locked for sure" (the medication refrigerator). CNS-C stated the medication refrigerator used to be located in the locked staff office however, it was moved. CNS-C stated they were working on improvements for the office and forgot to move the medication refrigerator back to the office. The licensee's 7.11 Medication Storage policy dated May 20, 2026, indicated when medications were managed and stored by the licensee, medications would be kept securely locked and stored per the manufacturer's directions. Only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for two of two residents (R1, R2) who	01890		

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	35868	A. BUILDING: _____ B. WING _____	07/28/2026

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01890	Continued From page 15 received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at 12:23 p.m., the surveyor observed the licensee's medication cart and observed the following expired medications: - one card of lorazepam 0.5 milligrams (mg) with an expiration date of April 11, 2026, for R1; - two cards of Tylenol 325 mg with an expiration date of April 9, 2026, and June 5, 2026 for R1; - five bottles polacrilex lozenge 2 mg. Two bottles had an expiration date of February 2026 and three bottles had an expiration date of June 2, 2026, for R1; - one bottle of lorazepam 0.5 mg with an expiration date of February 4, 2026, for R1; - two cards of acetaminophen 325 mg with an expiration date of April 6, 2026, for R2; - two boxes of sumatriptan 100 mg with an expiration date of April 14, 2026, for R2; and - one bottle of deep sea nasal spray 0.65 percent with an expiration date of April 14, 2026. On July 28, 2026, at approximately 1:10 p.m., during an interview with licensed assisted living director/registered nurse (LALD/RN)-D and clinical nurse supervisor (CNS)-C, CNS-C stated after a previous survey they disposed expired medications and disposed of a discharged	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35868	A. BUILDING: _____ B. WING _____	07/28/2026

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01890	Continued From page 16 resident's medications by sending them back to the pharmacy. CNS-C stated the nurses then performed a monthly check on medications and removed any medications that needed to be disposed of. The surveyor inquired why a monthly check on medications was not continued as the licensee's plan of correction following the previous survey indicated. CNS-C stated they forgot to check the medication cart and refrigerator; however, they planned on checking medications expirations dates moving forward. The licensee's 7.23 Medication Disposal policy dated May 20, 2026, indicated expired medications managed by the licensee will be disposed of according to the accepted practices of the Minnesota Board of Pharmacy and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 17 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of medications being managed by the licensee when the resident's medication management services ended for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R4 was admitted to the licensee on July 16, 2021, and began receiving assisted living services. R4 discharged from the licensee on April 2, 2026. R4's Service Plan (Waiver) - Addendum to Contract signed February 27, 2026, indicated R4 received assistance with appointments, behavior management, housekeeping, medication administration, blood glucose monitoring, and safety checks.	01910		

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01910	Continued From page 18 On July 27, 2026, at approximately 9:20 a.m., during a facility tour, the surveyor observed the licensee's medication refrigerator and observed the following medications for R4: -nine Lantus SoloStar pens; -16 NovoLog FlexPens; and - one Ozempic 2mg/3ml pen. On July 28, 2026, at approximately 1:10 p.m., during an interview with licensed assisted living director/registered nurse (LALD/RN)-D and clinical nurse supervisor (CNS)-C, CNS-C stated the licensee normally disposed of discharged resident's medications within a week or two of the resident discharging however, they forgot to check the medication refrigerator for R4's medication to dispose of them. The licensee's 7.23 Medication Disposal policy dated May 20, 2026, indicated the licensee shall dispose of any medication remaining with the facility that were discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. In addition, current unused medications managed by the licensee would be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications were no longer managed by the licensee or the medication had been discontinued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

, MN
Phone:

Food & Beverage Inspection Report

Establishment Info

GOLDEN OAKS HOME CARE LLC
7100 Maryland Ave N
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35868

Risk:
License:
Expires on:
CFPM: ASHLEY PALKAR
CFPM #: 13127; Exp: 5/15/2029

Inspection Info

Report Number: F1068261046
Inspection Type: Full - Single
Date: 7/27/2026 Time: 2:19:36 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THE INSPECTION WAS COMPLETED AND DISCUSSED WITH THE PERSON IN CHARGE AND HEALTH REGULATION DIVISION NURSING EVALUATOR, ASHLEY CREWS (MDH).

THE ESTABLISHMENT HAS A RESIDENTIAL GRADE KITCHEN, INCLUDING THE REFRIGERATOR AND DISH MACHINE. THE KITCHEN FINISHES ARE AS FOLLOWS:

FLOORS: VINYL PLANK
WALLS: SMOOTH, PAINTED DRYWALL AND TILE BACKSPLASH
CEILINGS: PAINTED

THE ESTABLISHMENT HAS A SCHEDULED MEAL MENU FOR RESIDENTS. THE PERSON IN CHARGE STATED THAT ALL FOOD PREPARED FOR RESIDENTS IS KEPT NO LONGER THAN A DAY, USING SAME DAY SERVICE.

FOOD FOR RESIDENTS IS SOURCED FROM HYVEE.

THE FOLLOWING TOPICS WERE DISCUSSED DURING THE INSPECTION:
-HANDWASHING & DISPOSABLE GLOVE USE
-SANITIZATION CYCLE ON THE RESIDENTIAL DISH MACHINE
-SERVING A HIGHLY SUSCEPTIBLE POPULATION
-SAME DAY SERVICE
-BODILY FLUID CLEAN-UP PROCEDURES
-EMPLOYEE ILLNESS POLICY AND REPORTING PROCEDURES

THE PERSON IN CHARGE PROVIDED A PICTURE OF A HIGH TEMP REGISTERING STICKER SHOWING THAT THE DISH MACHINE REACHED A TEMPERATURE OF 160 DEGREES F.

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

I acknowledge receipt of the inspection report number F1068261046 from 7/27/2026

STEVE MANDIEKA
PERSON IN CHARGE

Gabe Stark,
Public Health Sanitarian 2
gabe.stark@state.mn.us

, MN

DEPARTMENT OF HEALTH

Temperature Observations/Recordings

Establishment Info

GOLDEN OAKS HOME CARE LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1068261046
Inspection Type: Full
Date: 7/27/2026
Time: 2:19:36 PM

Food Temperature: Product/Item/Unit: TOMATO **; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT **; Temperature Process:** Ambient Air
Location: KITCHEN FREEZER at 7 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT **; Temperature Process:** Ambient Air
Location: GARAGE REFRIGERATOR at 39 Degrees F.
Comment:
Violation Issued?: No

, MN

Sanitizer Observations/Recordings

Establishment Info

GOLDEN OAKS HOME CARE LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1068261046
Inspection Type: Full
Date: 7/27/2026
Time: 2:19:36 PM

Sanitizing Equipment: **Product:** RESIDENTIAL DISH MACHINE **; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No