Electronically Delivered

April 8, 2025

Licensee
Gabby Care Homes LLC
1512 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL34026016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34026	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC	1512 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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 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 # SL34026016 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were seven (7) residents receiving services under the Assisted Living 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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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 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	0 680		

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0 680	Continued From page 2 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 emergency disaster preparedness plan lacked evidence of the following required content: -evacuation plan; and -quarterly review of missing resident policy. On March 6, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated the licensee's evacuation plan was missing, and the missing resident policy was reviewed, and he checked at the office, but was unable to provide this documentation. CNS-A stated the licensee would update the EPP to include the content listed above. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee EPP would include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 810		

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0 810	Continued From page 3 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly 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	0 810		

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0 810	Continued From page 4 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 potential to affect a large portion or all of the residents). The findings include: On March 6, 2025, at 10:15 a.m., clinical nurse supervisor (CNS) -A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: CNS-A was unable to provide fire safety evacuation plan. CNS-A stated he was unaware that the fire safety evacuation plan was missing, and he checked at another location but was unable to provide this documentation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS-A stated residents were provided the training once per year but lacked documentation showing any training was offered for residents on the fire safety and evacuation plan. The licensee failed to provide documentation of training to employees on the FSEP upon hire and at least twice per year. CNS-A stated that they were doing the training upon hire and twice per year but was only able to provide documentation for training on January 23, 2025.	0 810		

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0 810	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 6, 2025, at 9:30 a.m., the engineering	0 830		

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0 830	Continued From page 6 surveyor reported to the nurse surveyor that during her tour with clinical nurse supervisor (CNS)-A, she observed R2 was smoking in his room, and R2 had the bedroom windows open as to not set off the fire alarm. On March 6, 2025, at 9:45 a.m., nurse surveyor observed a cigarette butt in an ashtray in R2's room. R2 stated he knows that he is not supposed to smoke in his room. R2 stated he smokes at a designated smoking area, but he was feeling cold, so he decided to open the window and smoke in his room. On March 6, 2025, at 9:55 a.m. ULP-B stated R2 usually smokes at a designated smoking area, and she was surprised that R2 was found smoking in his room. R2 admitted to the facility on April 26, 2021. R2's diagnoses included schizoaffective disorder, post-traumatic stress disorder, and hypertension (high blood pressure). R2's Service Plan dated April 6, 203, indicated R2 received services including medication administration, activity assistance, behavior management, housekeeping, laundry, monitoring vital signs, and meal reminder. R2's 90 Day Assessment (Nursing) dated January 8, 2025, indicated the resident was a current smoker and assessment noted the following: - resident had a history of marijuana use. - smoking materials stored in his room; - resident is ware of the designated smoking areas; - no signs in the apartment of mishandled cigarettes such as burns in carpet or furniture;	0 830		

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0 830	Continued From page 7 - no signs of burning on the resident's clothing; and - resident able to smoke safely, independently, without intervention. On March 6, 2025, at 11:30 a.m. CNS-A stated residents were not allowed to smoke in the facility and there was a designated smoking area with a proper cigarette butt disposal container. CNS-A stated he was aware of some of residents who needed redirection from staff, but R2 usually goes outside to smoke, and this was the first time R2 was found smoking in his room. CNS-A provided document titled "Warning Letter for Violation of Smoking Policy" dated March 6, 2025 and further indicated R2 violated the smoking policy by smoking inside the building. The Minnesota Clean Indoor Air Act (MCIAA) indicated, "The Freedom to Breathe (FTB) provisions amended the Minnesota Clean Indoor Air Act (MCIAA) further protect employees and the public from the health hazards of secondhand smoke. These provisions went into effect on October 1, 2007. In 2019, the MCIAA was amended again to expand the definition of smoking to include vaping, the use of electronic delivery devices (also known as e-cigarettes or vapes). The amendment is effective on August 1, 2019. On August 1, 2023, adult-use cannabis was legalized in Minnesota. Vaping and smoking cannabis products is included in the definition of smoking under the MCIAA. Minnesota's cannabis law and local ordinances have additional requirements regarding the use of these products in the indoor environment. For more information, please contact the Office of Cannabis Management." The MCIAA defines smoking as inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, pipe or any other	0 830		

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0 830	Continued From page 8 lighted or heated product containing, made or derived from nicotine, tobacco, marijuana, or other plant intended for inhalation. As of August 1, 2019, this definition includes carrying or using an activated electronic delivery device. The licensee's 4.59 Smoking/Tobacco Use policy dated August 1, 2021, indicated "Indoor Smoking Prohibition: Smoking, including but not limited to cigarettes, cigars, pipes, vaping devices, and e-cigarettes, is strictly prohibited within any indoor space of [Licensee] including resident. Designated Smoking Areas: Smoking is only allowed in designated outdoor smoking areas specified by [Licensee]." No further information was provided. TIME PERIOD FOR CORRECTION: 2 days	0 830		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/03/25*
Time: 13:45:00
Report: 1013251015

Food and Beverage Establishment Inspection Report

Location:
Gabby Care Homes Llc
1512 Pennsylvania Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038555
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632048841
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.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: 1510 dish machine
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: 1512 dish machine
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Sanitizer - 1512 kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Fries
Temperature: 12 Degrees Fahrenheit - Location: 1510 freezer
Violation Issued: No

Process/Item: Milk
Temperature: 37 Degrees Fahrenheit - Location: 1510 refrigerator
Violation Issued: No

Process/Item: Cheese
Temperature: 39 Degrees Fahrenheit - Location: 1510 refrigerator
Violation Issued: No

Process/Item: Tofu
Temperature: 6 Degrees Fahrenheit - Location: 1512 freezer
Violation Issued: No

Type: Full
Date: *03/03/25*
Time: 13:45:00
Report: 1013251015
Gabby Care Homes Llc

Food and Beverage Establishment Inspection Report

Process/Item: Milk
Temperature: 37 Degrees Fahrenheit - Location: 1512 refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 37 Degrees Fahrenheit - Location: 1512 refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator S. Hassan. The kitchens at 1512 and 1510 were inspected for this survey (houses are connected).

The establishment has residential kitchens and serves food prepared that day.

The 1512 kitchen has wood cabinets, laminate floor, smooth painted walls, granite counter top, and a textured painted ceiling.

The 1510 kitchen has painted wood cabinets, wood vinyl floor, smooth painted walls, solid counter top, and a textured painted ceiling.

A two basin sink is located in both kitchens. One basin is designated for hand washing.

Residential dish machines are used to wash ware. Run the dish machines on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 1013251015 of 03/03/25.

Certified Food Protection Manager: Christine N. Morabu

Certification Number: 112811 Expires: 08/25/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Faith Omurwa
RN, LALD

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us