DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 21, 2025

Licensee
Generations Home Care Inc.
119 3rd Avenue Southeast
Saint Joseph, MN 56374

RE: Project Number(s) SL35678016

Dear Licensee:

On January 15, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

December 13, 2024

Licensee
Generations Home Care Inc.
119 3rd Avenue Se
Saint Joseph, MN 56374

RE: Project Number(s) SL35678016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 7, 2024, 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
	35678	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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 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: SL35678016-0 On November 5, 2024, through November 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five (5) resident(s); 5 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 2 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms and comply with State Fire Code. 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 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).	0 780		

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0 780	Continued From page 3 The findings include: On November 5, 2024, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. When smoke alarms on the main floor were tested, the smoke alarm in the basement was not actuated. During the facility tour interview on November 5, 2024, LALD-A verified the basement smoke alarm was not interconnected with the dwelling unit smoke alarms on the main floor as required by statute. 2. An inspection tag or sticker was not attached to the fire alarm panel showing an annual inspection had been completed on the fire alarm system. During the facility tour interview on November 5, 2024, LALD-A verified the fire alarm system had not been inspected in the last year. 3. An extension cord was used to supply power in resident sleeping room 2. Improper use of extension cords creates a fire hazard. During the facility tour interview on November 5, 2024, LALD-A verified the above listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	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,	0 790		

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0 790	Continued From page 4 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: Based on observation and interview, the licensee failed to install portable fire extinguishers as required by statute. This deficient condition had the potential to affect a limited number of residents and all staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 5, 2024, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. The fire extinguisher in the office was not mounted on the bracket. 2. The fire extinguisher outside bedroom 6 was hanging on the bracket using the discharge hose. Fire extinguishers must be mounted in a manner to prevent them from being moved or damaged. During the facility tour interview on November 5, 2024, LALD-A verified these fire extinguishers were not properly installed.	0 790		

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0 790	Continued From page 5 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 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.	0 810		

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0 810	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, make the plan readily available, and provide required drills. 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 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 November 5, 2024, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed resident sleeping room numbers were not posted on or adjacent to the resident's sleeping room doors. LALD-A verbally identified resident sleeping rooms as 1, 2, 3, 4, 5, and 6 during the tour. Sleeping room identifiers are required to be posted and must correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on November 5, 2024, LALD-A verified resident sleeping room identifiers were not posted. On November 5, 2024, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and	0 810		

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0 810	Continued From page 7 employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN During an interview on November 5, 2024, at 2:30 p.m., LALD-A stated the FSEP was stored in the locked closet in the office area. The fire safety and evacuation plan was not readily available at all times in a central location for all staff accessibility. The FSEP floor plan did not identify the basement. Accurate FSEP floor plans are required to develop fire safety and evacuation actions and procedures. The FSEP included a 9.06 Fire Safety Policy dated August 1, 2021. This policy was a template from a third-party provider and not developed for use at this facility. This FSEP fire policy failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these actions in the plan. The employee actions were limited to the RACE (Rescue, Alarm, Contain, Extinguish/Evacuate) acronym and the plan inaccurately referenced smoke compartment doors. The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan.	0 810		

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0 810	Continued From page 8 DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill reports lacking the required frequency. Five fire drills were completed between January and July of 2023. No fire drills were conducted between August and December 2023. During an interview on November 5, 2024, at 2:30 p.m., LALD-A verified the 2023 evacuation fire drill frequency was not met and stated the employee who had coordinated these drills had left. The 2024 evacuation fire drill frequency from January to November was in compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060		

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01060	Continued From page 9 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation one of two residents (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	01060		

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01060	Continued From page 10 problems are pervasive or represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 was admitted on February 15, 2024, and began receiving assisted living services. R3's Service Plan signed October 16, 2024, indicated R3's services included full assistance with dressing, grooming, feeding, toileting, and medication administration. R3's record included Progress Notes dated August 31, 2024, through September 12, 2024, and September 17, 2024, through September 23, 2024. R3's Progress Notes indicated R3 had been hospitalized September 6, 2024, through September 9, 2024, and again on September 19, 2024, through September 22, 2024. R3's record lacked evidence of a written notice provide to the resident, the resident's legal representative, and designated representative that contained at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident	01060		

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01060	Continued From page 11 may submit an appeal. On November 5, 2024, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-B stated they had not sent emergency relocation forms for any resident hospitalizations and were unaware it was a requirement until recently. The licensee's Emergency Relocation policy dated August 1, 2021, read "in the event of an emergency relocation, [licensee] will provide a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35678	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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
01620	Continued From page 12 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of three residents (R2, R3) and failed to ensure comprehensive nursing assessments were completed within the required 90-day timeframe for three of three residents (R2, R3, 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 a widespread scope (when	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35678	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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
01620	Continued From page 13 problems are pervasive or represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted on June 19, 2023, and began receiving assisted living services. R2's Service Plan dated June 30, 2024, indicated R2's services included dressing, grooming, and bathing assistance, medication administration, and catheter care. R2's record included two Uniform Assessment Tools containing all required content and dated June 19, 2023, and October 22, 2024. R2's file included four single page Generations forms dated September 20, 2023, March 15, 2024, June 24, 2024, and September 20, 2024. The Generations forms consisted of a single page with checkmarks indicating a 90-day or change in condition assessment, review of service plan, review of abuse prevention plan, review of side rails, and a signature line. All four forms were completed, signed, and dated by clinical nurse supervisor (CNS)-B. The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. R2's consecutive assessments completed on June 19, 2023, and September 20, 2023, indicated 93 days had passed between assessments. R2's consecutive assessments on September 20, 2023, and March 15, 2024, indicated 177 days	01620		

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	35678	A. BUILDING: _____ B. WING _____	11/07/2024

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GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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
01620	Continued From page 14 had passed between assessments. R2's consecutive assessments on March 15, 2024, and June 24, 2024, indicated 101 days had passed between assessments. R3 R3 was admitted on February 15, 2024, and began receiving assisted living services. R3's Service Plan dated October 17, 2024, indicated R3's services included total assistance with dressing, grooming, toileting, feeding, and medication administration. R3's file included an initial assessment completed on a Uniform Assessment Tool, containing all required elements, dated February 8, 2024. R3's file included four (4) single page Generations forms dated February 25, 2024, March 15, 2024, June 12, 2024, and September 10, 2024. One Generations form was undated. The forms consisted of a single page with checkmarks indicating a 90-day or change in condition assessment, review of service plan, review of abuse prevention plan, review of side rails, and a signature line. All 4 forms were completed, signed, and dated by clinical nurse supervisor (CNS)-B. The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. R3's consecutive assessments on March 15, 2024, and June 12, 2024, indicated 92 days had passed between assessments. R4 R4 was admitted on July 27, 2024, and began receiving assisted living services.	01620		

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01620	Continued From page 15 R4's Service Plan dated July 29, 2024, indicated R4's services included assistance with dressing, grooming, and bathing, transfers, and medication assistance. R4's record included Uniform Assessment Tools dated July 23, 2024, and October 22, 2024. R4's consecutive assessments completed on July 23, 2024, and October 22, 2024, indicted 91 days had passed between assessments. On November 5, 2024, at 1:48 p.m., CNS-B stated they were unaware of the requirement of using a uniform assessment tool for all assessments and have recently learned of the requirement. CNS-B stated they were "doing the assessments under the old law so they were incorrect." Minnesota Administrative Rule 4659.0150 effective August 1, 2021, indicated each licensee must develop a uniform assessment tool containing all elements identified under Subpart 2 of the Rule. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated July 26, 2022, indicated the following: -the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required; -resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of assisted living services; and -ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 days from the date of the last assessment.	01620		

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01620	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for two of two residents (R2, R4)	01640		

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01640	Continued From page 17 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 the residents). The findings include: R2 R2 was admitted on June 19, 2023, and began receiving assisted living services. R2's Service Plan signed June 30, 2024, indicated R2's services included assistance with dressing, grooming, and bathing, medication administration, and catheter care. On October 9, 2024, licensee received an order for compression stockings for R2. The licensee failed to revise the service plan to reflect current services provided to R2. On November 6, 2024, at approximately 10:36 a.m., R2 stated he wears compression socks daily. R4 R4 was admitted on July 24, 2024, and began receiving assisted living services. R4's Service Plan signed July 29, 2024, indicated R4's services included assistance with dressing, grooming, and bathing, transfer assistance, and medication administration. The Service Plan indicated R4 required transfers with assistance of one to two people using an EZ stand (a device to	01640		

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01640	Continued From page 18 assist with transfers). On November 5, 2024, at approximately 2:00 p.m., unlicensed personnel (ULP)-C stated R4 could transfer herself between bed and chair using a gait belt and the standby assistance of one staff member. On November 6, 2024, at approximately 12:30 p.m., R4 stated she pivot transfers with the use of a gait belt and the assistance of one person. On November 6, 2024, at approximately 3:00 p.m., licensed practical nurse (LPN)-E stated she was responsible for developing and revising the service plans and she thought R4's service plan had been updated. LPN-E stated R2 wears compression stockings daily and she had not updated R2's service plan as the order was recently obtained, and The licensee's 6.08 Service Plan policy dated July 26, 2022, indicated all residents would have a service plan in place and all service plans would be revised based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 19 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current individualized treatment management record was developed to include the required content for two of two residents (R2, 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) and was issued at a widespread scope (when problems are pervasive	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 20 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on June 19, 2023, and began receiving assisted living services. R2's Service Plan signed on June 30, 2024, indicated R2's services included assistance with dressing, grooming, and bathing, medication administration, and catheter care. R2's record included a prescriber order for compression stockings dated October 9, 2024. R2's record included an Individualized Treatment or Therapy Management Plan dated October 22, 2024, indicating treatments provided included catheter care. R2's treatment plan lacked revisions to include compressions stockings as a treatment provided and delegated to unlicensed personnel (ULP). R4 R4 was admitted on July 27, 2024, and began receiving assisted living services. R4's Service Plan signed on July 29, 2024, indicated R4's services included assistance with dressing, grooming, and bathing, medication administration, assistance with application and removal of ankle-foot orthoses (AFO) and braces, assistance with transfers, and treatments as noted in treatment book. R4's record included an Individualized Treatment and Therapy Management Plan dated October	01940		

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01940	Continued From page 21 22, 2024, indicated treatments received by R4 included blood glucose monitoring and oxygen management. R4's treatment plan lacked identification of brace/AFO assistance and CPAP (breathing support machine used when sleeping) as services to be provided and delegated to ULP. On November 6, 2024, at approximately 2:30 p.m., R4 stated she used her CPAP every night and staff assisted her with application and starting the machine. On November 6, 2024, at approximately 3:30 p.m., clinical nurse supervisor (CNS)-B stated they were responsible for developing and updating the treatment and therapy plans. CNS-B stated they were unaware the treatment plans for R2 and R4 were incomplete. The licensee's 7.05 Treatment and Therapy Management Plan policy dated November 5, 2021, indicated [licensee] would develop and maintain a current individualized treatment and therapy management record for each resident and that treatment or therapy management plans would be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	01960		

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01960	Continued From page 22 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of administration of or the reason why a treatment was not administered and any follow-up procedures that were provided for one of two residents (R4) receiving treatments. 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 ab 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 on July 27, 2024, and began receiving assisted living services. R4's Service Plan signed July 29, 2024, indicated R4's services included dressing, grooming, and bathing assistance, medication administration, assistance with application and removal of braces and ankle-foot orthoses (AFOs), and treatments as indicated in treatment book. R4's record included a Treatment Record for	01960		

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01960	Continued From page 23 September 2024, indicating the following treatments: 1. Has AFO's: knee brace; leg wraps; wrist brace. She decides which she wants to wear. Assist with placement and removal at bedtime. R4's record lacked documentation of administration or R4 refusal of brace/AFO assistance on the following dates: September1, 2, 6, 7, 9. 10, 11, 14, 15, 16, 17, 19, 21, 20 and 30, 2024. 2. At bedtime, fill CPAP reservoir with water and turn CPAP on. R4's record lacked documentation of administration or R4's refusal of CPAP on the following dates: September 1, 2, 3, 4, 5, 6, 10, 16, 17, 19, 21, 22, 25, 26, 28, 29, 30. On November 6, 2024, at approximately 3:30 p.m., licensed practical nurse (LPN)-E stated they were responsible for monitoring medication and treatment records for verification of administration and documentation. LPN-E stated they were unaware of the omissions in treatment documentation in R4's record and must have "missed that" during record review. The licensee's 7.22 Medication and Treatment Record- Documentation and Refusal policy dated October 24, 2024, indicated documentation will include the signature and title of the authorized person administering the medication or treatment. The policy also indicated if the medication or treatment were not administered as prescribed, the documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *11/05/24*
Time: 11:10:36
Report: 1041241253

Food and Beverage Establishment Inspection Report

Location:
Generations Home Care Inc
Generation Home Care Inc.
119 3rd Avenue SE
St Joseph, MN56374
Stearns County, 73

Establishment Info:
ID #: 0038412
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202828074
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.

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

AT TIME OF INSPECTION, THERE WAS A BAG OF RICE STORED ON THE FLOOR OF THE DRY STORAGE AREA. STORE FOOD ON SHELVES.

Comply By: 11/05/24

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE SLOW COOKERS, CROCK POT, AND QUESADILLA MAKER ARE NOT APPROVED. REMOVE AND REPLACE WITH NSF/ANSI APPROVED EQUIPMENT.

Comply By: 11/19/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

PROVIDE A THERMOMETER IN THE UPRIGHT COOLER.

Comply By: 11/19/24

Type: Full
Date: *11/05/24*
Time: 11:10:36
Report: 1041241253
Generations Home Care Inc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MACARONI SALAD
Violation Issued: No

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

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 1041241253 of 11/05/24.

Certified Food Protection Manager RHESA MASSMANN

Certification Number: 119168 Expires: 09/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us