



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 8, 2025

Licensee
Generous Home Care Services
3835 Saratoga Lane North
Plymouth, MN 55441

RE: Project Number(s) SL36234016

Dear Licensee:

On May 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 13, 2025. 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,

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

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 18, 2025

Licensee
Generous Home Care Services
3835 Saratoga Lane North
Plymouth, MN 55441

RE: Project Number(s) SL36234016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

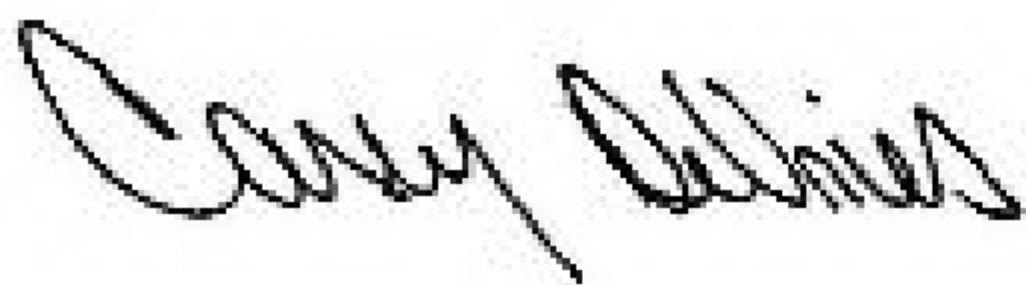
the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER GENEROUS HOME CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3835 SARATOGA LANE NORTH PLYMOUTH, MN 55441		
(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: SL36234016-0 On February 10, 2025, through February 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both received 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (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 that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs for one of two residents (R2). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 or a violation that has the potential to lead to 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 held an assisted living license and was licensed for a capacity of four residents. At the time of the survey, there were two residents, both received services from the licensee. The licensee's undated Facility Staffing Plan indicated one direct care staff would be available each shift Monday through Sunday for the following shifts: -morning (AM) shift 8:00 a.m., to 2:00 p.m., -evening (PM) shift 2:00 p.m., to 11:00 p.m., and -overnight (NOC) shift 11:00 p.m., to 8:00 a.m. On February 11, 2025, at 10:40 a.m., R2 stated they were left alone by themselves with no staff or other residents in the building for up to four to five hours on some days. R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident (stroke). R2's Client Evaluation (admission assessment) dated March 13, 2023, indicated R2 had vision loss (partial blindness in the one eye (the right eye)). The admission assessment, a five-page document, lacked inclusion of all areas required by MN Rule 4659.0150 Subdivision 2. R2's subsequent assessments, including the most recent assessment dated September 4, 2024,	0 470			

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0 470	Continued From page 3 was a two-page document, which indicated physical exam body system line items such as neurosensory, cardiovascular, respiratory, gastrointestinal, etc., and included areas to check whether there had been a change or no change from the last assessment. The subsequent assessment also lacked inclusion of all areas required by MN Rule 4659.0150 Subdivision 2. R2's record lacked a current comprehensive assessment. R2's Service Plan dated March 13, 2023, indicated home health aide service/care plan available 24 hours a day and 7 days a week. The service plan indicated R2 received assistance for the following services: clothing, oral care, shampoo, shaving, nail care, skin care, plate set up at mealtimes, medication administration, weekly blood pressure checks, housekeeping, shopping, linen changes, and laundry. The licensee's Uniform Disclosure of Assisted Living Service and Amenities (UDALSA), signed and dated by R2 on April 27, 2024, page 2, indicated: "unlicensed staff are in the building and available to respond to resident request 24/7". The licensee's Emergency Evacuation Plan signed and dated by R2 on June 20, 2024, indicated: "Evacuation Procedures Fire or Emergency Alarm Activation: The staff member will immediately assess the situation to determine if evacuation is necessary. Staff will guide both clients toward the exit at the same time, keeping them close and providing verbal instructions to maintain calm. Escort both clients out of the building using the closest and safest exit route. Lead them toward the designated safe meeting point at the mailbox. Staff will provide verbal	0 470			

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0 470	Continued From page 4 guidance and reassurance to clients who may need emotional support during the evacuation. Once outside, the staff member should ensure that both clients are safely escorted to the mailbox. Upon arrival at the mailbox, conduct a headcount to confirm that both clients are present and safe. The staff member will remain in verbal communication with both clients throughout the evacuation process, providing clear and calm instructions." On February 11, 2025, at 10:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they have staff available 24/7, however, they do not get paid for 24 hours in a day for R2; R2 can stay by themselves sometimes if staff had to take R1 to appointments. LALD/CNS-C further stated R2's case worker told them verbally that R2 could be left alone for up to nine hours a day. R2's service plan and assessment did not indicate the plan to leave R2 by themselves for up to nine hours a day. On February 11, 2025, at 11:45 a.m., unlicensed personnel (ULP)-B stated they took R1 to social activities twice a week, and to shopping centers up to two to three times a week for about one to two hours a day. ULP-B stated R2 stayed at home by themselves when they took R1 to social activities. ULP-B further stated R2 sometimes went out to shopping centers with R1 but not always. On February 11, 2025, at 12:00p.m., LALD/CNS-C stated even though R2 only paid for 14 hours a day, R2 had 24 hours supervision before the licensee admitted R1, who needed to go out to certain activities. LALD/CNS-C stated	0 470			

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0 470	Continued From page 5 after the licensee admitted R1, they did not have to hire another staff since R2 can stay by themselves for up to nine hours per day. The licensee's Staffing policy dated February 24, 2022, indicated "5. Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	0 550			

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0 550	Continued From page 6 Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 11:02 a.m. during the facility tour, the surveyor observed contact information for office of ombudsman for long term care facility (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Minnesota Adult Abuse Reporting Center (MAARC) posted on a bulletin board on the hallway. The surveyor observed the licensee lacked the following postings: - OHFC. On February 10, 2025, at 11:19 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they thought OOLTC contact information was the same as OHFC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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0 630	Continued From page 7	0 630			
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 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 one of two residents (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 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: R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident.	0 630			

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0 630	Continued From page 8 R2's Service Plan dated March 13, 2023, indicated R2 received assistance for the following services: clothing, oral care, shampoo, shaving, nail care, skin care, plate set up at mealtimes, medication administration, weekly blood pressure checks, housekeeping, shopping, linen changes, and laundry. R2's undated IAPP indicated R2 was at risk for abusing other vulnerable adults and was unable to report abuse/ neglect concerns. R2's IAPP did not include the required statements of the specific measures to be taken to minimize the risk of abuse to that person. On February 11, 2025, at 12:00 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated the IAPP did not address the interventions because they thought interventions were only needed for the case worker; LALD/CNS-C further stated they did put interventions on a form for R2's case worker, but they did not have the copy of the form saved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640			

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0 640	Continued From page 9 (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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: On February 10, 2025, at 11:02 a.m., the surveyor observed one black and silver wireless landline phone on a small table, in the living room area, which lacked the required posting of the 911 emergency number. On February 10, 2025, at 11:02 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated the phone was used by residents and staff. LALD/CNS-C stated the licensee was not aware of the requirement and would post 911 emergency number by the phone.	0 640			

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0 640	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-A, ULP-B).	0 650			

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NAME OF PROVIDER OR SUPPLIER GENEROUS HOME CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3835 SARATOGA LANE NORTH PLYMOUTH, MN 55441		
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0 650	Continued From page 11 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: RN-D was hired on October 18, 2023, to provide supervision and oversight to unlicensed personnel and to provide direct care services to residents. ULP-A was hired on October 30, 2022, to provide direct care services to residents. ULP-B was hired on August 1, 2021, to provide direct care services to residents. RN-D, ULP-A and ULP-B's employee records lacked documentation of annual performance reviews identifying areas of improvement needed and training needs. On February 12, 2025, at 12:42 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they were not aware of the requirement to do annual performance reviews and did not do the annual performance reviews for any employees. LALD/CNS-C further stated they only did 30-day supervision for employees upon hire. The licensee's Performance Evaluation policy dated February 24, 2022, indicated a formal performance review evaluation will be conducted	0 650			

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0 650	Continued From page 12 for all staff providing cares at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of three employees (unlicensed personnel (ULP)-B, registered nurse (RN)-D).	0 660			

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0 660	Continued From page 13 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: RN-D RN-D was hired on October 18, 2023, to provide supervision and oversight to unlicensed personnel and to provide direct care services to residents. RN-D's employee record included the baseline TB symptom screening and health history completed on October 18, 2023. RN-D's employee record also included QuantiFERON-TB- gold plus result dated June 29, 2022. RN-D's employee record lacked TST or other evidence of TB screening such as a blood test, dated within 90 days before hire. ULP-B ULP-B was hired on August 1, 2021, to provide direct care services to residents. ULP-B's employee record included undated Baseline TB Screening Tool for Health Care Workers with a completed health history and baseline TB symptom screening for ULP-B. ULP-B'S employee record also included a test result from Minute Clinic which indicated ULP-B received the first step TST on January 28, 2022, with negative results read on January 30, 2022. ULP-B's employee record lacked evidence the second step TST was completed or other	0 660			

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0 660	Continued From page 14 evidence of TB screening such as a blood test, was completed, within 90 days before hire. On February 12, 2025, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they thought they had everything related TB for ULP-B; LALD/CNS-C stated they would ask ULP-B if they had the second step TST screening done. On February 12, 2025, at 12:40 p.m., LALD/CNS-C stated they did not do TB test for RN-D upon hire because they stated a previous surveyor told them a TB test was good for two years. On February 12, 2025, at 12:45 p.m., ULP-B stated they did take the first TST, but they did not remember if they did do the second step TST. The licensee's Tuberculosis Screening/Prevention Policy dated February 24, 2022, indicated "Baseline testing is completed on hire for all direct care providers and anyone who visits residents (including volunteers). Test results 1) provide a basis for comparison in the event of a potential or known exposure to M. tuberculosis and 2) facilitate the detection and treatment of LTBI or TB disease in a staff member before employment begins and reduces the risk to patients and other staff members. 1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 2. Baseline screening includes an assessment for TB history and current TB symptoms. 3. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results. 4. The baseline test may be either TST (2-step) or BAMT.	0 660			

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0 660	Continued From page 15 5. If the first-step TST is negative, the second-step TST will be administered 1--3 weeks after the first TST result was read. 6. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis. Additional TB screening is not necessary unless an exposure to M. tuberculosis occurs. 7. Written documentation for all TST results includes the mm induration, the interpretation (either positive or negative), the date read and a signature on letterhead. 8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: - o Assess for current TB symptoms - o If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. - o If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. - o Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. - o After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. 9. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use.	0 660			

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0 660	Continued From page 16 10. Employees with a documented history of prior treatment for LTBI or active TB disease do not need a TST or BAMT: - o Assess for current TB symptoms. - o Keep written documentation on file of a chest x-ray indicating no active TB disease that is dated after the date of the initial diagnosis of LTBI or active TB disease. - o Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. "Repeat chest x-rays are not needed unless symptoms or signs of active TB disease develop or a clinician recommends a repeat chest radiograph. "Consult with the MOH TB Prevention and Control Program (651-201-5414) regarding employees with a history of previous active TB disease, as needed. 11. Employees with a newly-identified positive TST or BAMT: - o Assess for current TB symptoms and risk factors for progression to active TB disease. - o Obtain a chest x-ray to exclude a diagnosis of active infectious TB disease before direct resident contact. - o For employees with LTBI, consult a physician regarding the need for treatment to prevent progression to active TB disease. - o After documentation of negative results from a baseline chest x-ray, repeat x- rays are not needed unless signs/symptoms of active TB disease develop or a clinician recommends a repeat chest x-ray. - o Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. 12. Pregnant employees	0 660			

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0 660	Continued From page 17 - o Pregnant and nursing women will be included in the same baseline and serial TB screening program as other health care workers. Pregnancy is not a contraindication for TB skin testing. - o A pregnant employee with a newly identified positive TST or BAMT or signs and symptoms of active TB disease is at increased risk for active TB disease and can receive a chest radiograph, using an abdominal shield. 13. A second TST is not needed if the employee has a documented TST result within 90 days of date of hire. If a new employee has had a documented negative TST result within the previous 90 days, a single TST can be administered in the new setting before providing care. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of M. tuberculosis in the setting. 14. If the second test result of a two-step TST is not read within 48--72 hours, administer a TST as soon as possible (even if several months have elapsed) and ensure that the result is read within 48--72 hours. 15. All reports or copies of the TST or BAMT, chest x-ray results and medical examinations will be maintained in the employee's record. 16. Any employee with symptoms consistent with active TB disease, regardless of the results of the TST or TB blood test, must be evaluated by a physician within 72 hours in order to exclude a diagnosis of active TB disease and may not return to work until determined to be non-infectious. The evaluation should include a medical examination and symptom screen, a chest x-ray and collection of sputum specimens or additional testing if indicated. If active TB disease is confirmed or suspected, the	0 660			

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0 660	Continued From page 18 diagnosing clinician should notify the Minnesota Department of health within one working day." The CDC document titled Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Minnesota Department of Health document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's Tuberculosis: Care Staff policy dated December 19, 2023, indicated, "The Community will screen all care staff for tuberculosis (TB) infection and disease, per state regulations prior to the start of employment and annually thereafter." No further information was provided.	0 660			

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0 660	Continued From page 19	0 660			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 an emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 20 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 Emergency Preparedness plan last reviewed on July 5, 2024, lacked evidence of the following required content: - strategies for addressing facility and community-based risks (evacuation plans, staffing, surges/shortages, back-up plans); - names and contact information; - process for EP collaboration with local, tribal, regional and State and Federal; - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - emergency official contact information; - primary and alternative means for communication; - methods for sharing information; - sharing information on occupancy and needs; - long-term care family notifications; - emergency preparation and testing requirements and; - quarterly review of missing resident. On February 10, 2025, at 10:45 a.m., licensed	0 680			

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0 680	Continued From page 21 assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they did review the missing resident policy twice a year, but they did not do documentation of the review and stated "missing resident policy is reviewed twice a year, my problem is I do not document. I did not do any documentation." On February 10, 2025, at 12:20 p.m., LALD/CNS-C stated the consultant took everything out of the EP binder and put it somewhere else and then it disappeared. LALD/CNS-C stated they were aware they were missing some required contents from the EP plan and purchased new manual from different company to correct the EPP. The licensee's Emergency Preparedness policy, dated February 24, 2022, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident Policy dated February 24, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at lease quarterly. Minnesota Administrative Rule 4659.0110, Subp 4. dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 730	Continued From page 22	0 730			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

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0 730	Continued From page 23 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document provided services for two of two residents (R1, R2) in resident records 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 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 September 20, 2023. R1's diagnosis included schizophrenia. R1's Exhibit 2: Service Plan dated September 20, 2023, indicated R1 received services for dressing, oral care, bathing, shampoo, shaving, nail care, skin care, foot care, plate set up, verbal encouragement to eat, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry.	0 730			

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0 730	Continued From page 24 R1's Services Charting Sheet from February 1, 2025, through February 7, 2025, lacked the following documentation for services provided during multiple shifts: - 1 of 7 scheduled services for daily reminders for oral care; - 5 of 7 scheduled services for daily reminders for shampoo; - 7 of 7 scheduled services for daily reminders for shaving; - 7 of 7 scheduled services for daily reminders for nail care; - 7 of 7 scheduled services for daily reminders for foot care; - 3 of 7 scheduled services for daily reminders for skin care; and - 13 of 21 scheduled services for assistance with meal plate set-up. R2 R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received services for dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's Services Charting Sheet from February 1, 2025, through February 7, 2025, lacked the following documentation for services provided during multiple shifts: - 4 of 7 scheduled services for daily reminders for clothing;	0 730			

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0 730	Continued From page 25 - 4 of 7 scheduled services for daily reminders for oral care; - 4 of 7 scheduled services for daily reminders for shampoo; - 4 of 7 scheduled services for daily reminders for shaving; - 4 of 7 scheduled services for daily reminders for nail care; - 4 of 7 scheduled services for daily reminders for skin care; and - 13 of 21 scheduled services for assistance with meal plate set-up. On February 12, 2025, at 11:50 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they were aware staff had not documented services on certain days. LALD/CNS-C further stated they would do an investigation and provide retraining to the staff providing care as needed. The Licensee's Verbal Reminders for Medications, Treatments, and Exercises policy dated February 24, 2022, indicated home health aides will document in the clinical record the provision of verbal reminders to resident for medication, treatments, and exercises. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

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0 775	Continued From page 26 by: Based on observation and interview, the licensee failed to provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. 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: On January 14, 2025, from 10:15 a.m. to 10:50 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. The following was observed. On resident rooms 4 and 5 there were hasp locks installed on the outside of the resident room doors. LALD/CNS-C stated that the residents had installed the hasp locks because they wanted them. The hasp locks were removed from the resident room doors during survey. Doors shall be openable from the egress side without special knowledge tools or effort. LALD/CNS-C indicated that the designated smoking area was located outside the service door to the garage in the back yard. There was no ashtray in the area, and cigarette butts were being discarded onto the ground.	0 775			

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0 775	Continued From page 27 Cigarettes shall be discarded into a sturdy noncombustible ashtray placed on a sturdy surface. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 smoke alarms that functioned	0 780			

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0 780	Continued From page 28 and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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: On February 11, 2025, from 10:15 a.m. to 10:50 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. Survey staff asked O/HM-B to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that none of the smoke alarms in the facility were interconnected. All smoke alarms only sounded locally. LALD/CNS-C stated that they had tested the smoke alarms the day prior and they were interconnected. LALD/CNS-C stated that they were not sure why the smoke alarms were not interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			

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0 790	Continued From page 29	0 790			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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). The findings include: On November 18, 2024, from 11:40 a.m. to 12:30 p.m., the surveyor toured the facility with owner/housing manager (O/HM)-B. The portable fire extinguishers throughout the facility lacked records to show monthly visual	0 790			

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0 790	Continued From page 30 inspections were complete. The dial on the fire extinguisher next to the kitchen indicated that the fire extinguisher was empty. The fire extinguisher was also missing the retention band to hold the safety pin in place. 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) 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	0 810			

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0 810	Continued From page 31 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and 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 February 11, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C 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: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific	0 810			

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0 810	Continued From page 32 employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. 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. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-C stated that all the employee training is done through Educare and not on the facilities FSEP. No other training documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of nine employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on January 29, 2022, to provide	01290			

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01290	Continued From page 34 direct cares and services to residents. The licensee's NetStudy 2.0 employee roster (web-based system for submitting background study requests to the Department of Human Services (DHS)), which the licensee accessed and printed on February 10, 2025, indicated ULP-E was affiliated under the licensee's pervious health facility identification number (HFID) #34867. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the current HFID #36234. On February 10, 2025, at 12:51 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were able to transfer all employees to the new HFID, but they were unable to transfer ULP-E. LALD/CNS-C stated they would contact DHS to resolve the issue. The licensee's Recruitment and Hiring Policy, dated February 24, 2022, indicated the licensee's employee may enter their own background study demographics information using the facility identification number provided and results of background study will be maintained in employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500			

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01500	Continued From page 35 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500			

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01500	Continued From page 36 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B ULP-B was hired on August 1, 2021, to provide direct care services to residents. ULP-B's employee record included the following required training topics:	01500			

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01500	Continued From page 37 - assisted living bill of rights completed on June 7, 2024; - infection control techniques completed on April 4, 2024; - principles of person-centered planning and service delivery completed on April 28, 2024; and - vulnerable adult completed on April 23, 2024. ULP-B's employee record lacked the following annual training topics completed within the last 12 months: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of provider's policies and procedures. On February 12, 2025, at 12:32 p.m., LALD/CNS-C stated they did not have the following topic on their list of trainings: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. The licensee's Staff Orientation and Education dated February 24, 2022, indicated all staff providing assisted living services will complete at least eight hours of training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01530	Continued From page 38	01530			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least two hours of annual dementia care training for each 12 months of employment for one of three employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530			

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NAME OF PROVIDER OR SUPPLIER GENEROUS HOME CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3835 SARATOGA LANE NORTH PLYMOUTH, MN 55441		
(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
01530	Continued From page 39 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: RN-D was hired on October 18, 2023, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. RN-D's employee record included a Dementia Training Tracking Form completed October 18, 2023. However, the employee record lacked two hours of annual dementia training which was due to be completed by October 18, 2024. On February 12, 2025, at 12:20 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated RN-D received training at another assisted living facility where RN-D worked. LALD/CNS-C stated they would ask RN-D to provide the training documents. LALD/CNS-C was unable to provide the annual training documents to the surveyor. The licensee's Dementia Education dated February 24, 2022, indicated, supervisors of direct-care staff must have at least two hours of dementia care training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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01610	Continued From page 40	01610			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's resident admission assessment comprised of multiple records (Client Evaluation, Individualized Medication Management Plan, admission progress notes, and Individualized Abuse Prevention Plan) failed to include all the required content of the uniform assessment tool for one of two residents (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 was issued at an isolated scope (when one or a	01610			

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01610	Continued From page 41 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: On February 12, 2025, at approximately 1:35 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C provided the surveyor with a 27-page blank admission assessment packet titled Resident Evaluation and stated it was what they would use for a new admission. The Resident Evaluation document covered required content indicated by the uniform assessment tool. However, the license did not utilize the Resident Evaluation document for R2, instead they used a different five-page form titled Client Evaluation. The Client Evaluation form did not include the required content of the uninform assessment tool. R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received services for dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's admission assessment form entitled Client Evaluation dated March 13, 2023, lacked the following areas required on the uniform assessment tool per Minnesota Rules Chapter 4659.0150: A. the resident's personal lifestyle preferences, including:	01610			

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01610	Continued From page 42 (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; and (2) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. B. instrumental activities of daily living, including: (1) transportation C. physical health status, including: (1) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; and (2) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (b) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (c) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; D. emotional and mental health conditions, including: (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders; (2) current symptoms of mental health	01610			

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01610	Continued From page 43 conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; E. cognition, including: (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability. F. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1). G. the need for follow-up referrals for additional medical or cognitive care by health professionals. On February 11, 2025, at 2:09 p.m., LALD/CNS-C stated they followed the forms they bought from a consulting firm and they believed the forms followed the statue requirements as a previous surveyor did not show any concern with the forms. The licensee's Comprehensive Nursing Assessment policy dated February 24, 2022, indicated, "1. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses the following a. Head to Toe Evaluation i. Current Medical and Nursing Diagnoses/Health Conditions ii. Communication and Sensory Capabilities 1. Hearing 2. Vision 3. Speech 4. Assistive Communication and Sensory Devices, including	01610			

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01610	Continued From page 44 a. Hearing Aids b. The Ability to Understand and be Understood iii. Activities of Daily Living iv. Instrumental Activities of Daily Living v. Skin/Integument Status vi. Digestive/Nutritional Status, including 1. Hydration 2. Diet 3. Food Allergies 4. Weight vii. Respiratory Status 1. Seasonal Allergies viii. Urinary Status ix. Joint/Muscle Status x. Endocrine xi. Cardiovascular, including 1. Vital Signs xii. Neurological Status xiii. Pain, including 1. Location, Frequency, Intensity and Duration 2. Effectiveness of Medications and Nonmedication Interventions xiv. Infectious Conditions xv. Mental/Emotional Health, including 1. Cognition, including a. Review of Neurocognitive Evaluations and Diagnoses b. Current Memory, Orientation, Confusion and Decision-Making Status and Ability 2. History/Diagnoses of Mood Disorders, such as a. Depression, b. Anxiety c. Bipolar Disorder d. Thought or Behavioral Disorders 3. Current Symptoms of Mental Health Conditions and Behavioral Expressions of Concern	01610			

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01610	Continued From page 45 4. Effective Medication Treatment and Nonmedication Interventions xvi. Psychological Status, including Losses xvii. Lifestyle Preferences, including 1. Social Supports/Needs 2. Sleep schedule 3. Leisure Activities 4. Prior Housing Situation(s) 5. Smoking, including Safety Factors 6. Alcohol/Drug Use (nonprescribed) xviii. Spiritual Assessment xix. Cultural Assessment xx. Safety Factors xxi. Health History, including: 1. Access of Health Care over Past 12 Months, including a. Medical Visits (PCP) b. Hospitalizations c. Surgeries d. Post-Acute In-Patient Care e. Dental Visits f. Emergency Room Visits 2. Reports from Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Evaluations within Past 12 Months b. Vulnerability Assessment, including Risk for Elopement c. Falls Risk Assessment d. SLUMS (if appropriate) e. Nutritional Assessment (if appropriate) f. Medications* i. Medication Allergies g. Emergency Information, including Evacuation Level** h. End of Life Preferences, including i. Health Care Directives ii. "DNR/DNI" orders iii. POLST"	01610			

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01610	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
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 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	01620			

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01620	Continued From page 47 uniform assessment tool per Minn Rule 4659.0150 for one of two residents (R1). 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 was admitted to the licensee on September 20, 2023, and started receiving assisted living services. R1's diagnosis included schizophrenia. R1's Exhibit 2: unsigned Service Plan dated September 20, 2023, indicated R1 received assistance with dressing, clothing, oral care, bathing, shampoo, shaving, nail care, skin care, foot care, plate set up, verbal encouragement to eat, verbal reminders to take medication, medication administration, weekly blood pressure, shopping, clean bedroom, change linens, vacuum, dust, and laundry. R1's 90-day assessment documented in a progress note on January 2, 2025, lacked the following areas required on the uniform assessment tool per Minnesota Rules Chapter 4659.0150: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; and	01620			

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01620	Continued From page 48 (2) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation" order or "physician/provider orders for life-sustaining treatment" order. B. physical health status, including: (1) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; and (2) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (b) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (c) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; C. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1). On February 12, 2025, at 1:44 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated despite having a specific assessment form available for 14-day and 90-day assessments, they often documented	01620			

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01620	Continued From page 49 assessments in their progress notes. The surveyor observed all of R1's 90-day assessments except the one completed on October 3, 2024, were documented in progress notes and followed the same format as the assessment completed on January 2, 2025. The licensee's Comprehensive Nursing Assessment policy dated February 24, 2022, indicated, " 1. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses the following a. Head to Toe Evaluation i. Current Medical and Nursing Diagnoses/Health Conditions ii. Communication and Sensory Capabilities 1. Hearing 2. Vision 3. Speech 4. Assistive Communication and Sensory Devices, including a. Hearing Aids b. The Ability to Understand and be Understood iii. Activities of Daily Living iv. Instrumental Activities of Daily Living v. Skin/Integument Status vi. Digestive/Nutritional Status, including 1. Hydration 2. Diet 3. Food Allergies 4. Weight vii. Respiratory Status 1. Seasonal Allergies viii. Urinary Status ix. Joint/Muscle Status x. Endocrine xi. Cardiovascular, including 1. Vital Signs xii. Neurological Status	01620			

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01620	Continued From page 50 xiii. Pain, including 1. Location, Frequency, Intensity and Duration 2. Effectiveness of Medications and Nonmedication Interventions xiv. Infectious Conditions xv. Mental/Emotional Health, including 1. Cognition, including a. Review of Neurocognitive Evaluations and Diagnoses b. Current Memory, Orientation, Confusion and Decision-Making Status and Ability 2. History/Diagnoses of Mood Disorders, such as a. Depression, b. Anxiety c. Bipolar Disorder d. Thought or Behavioral Disorders 3. Current Symptoms of Mental Health Conditions and Behavioral Expressions of Concern 4. Effective Medication Treatment and Nonmedication Interventions xvi. Psychological Status, including Losses xvii. Lifestyle Preferences, including 1. Social Supports/Needs 2. Sleep schedule 3. Leisure Activities 4. Prior Housing Situation(s) 5. Smoking, including Safety Factors 6. Alcohol/Drug Use (nonprescribed) xviii. Spiritual Assessment xix. Cultural Assessment xx. Safety Factors xxi. Health History, including: 1. Access of Health Care over Past 12 Months, including a. Medical Visits (PCP) b. Hospitalizations c. Surgeries	01620			

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01620	Continued From page 51 d. Post-Acute In-Patient Care e. Dental Visits f. Emergency Room Visits 2. Reports from Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Evaluations within Past 12 Months b. Vulnerability Assessment, including Risk for Elopement c. Falls Risk Assessment d. SLUMS (if appropriate) e. Nutritional Assessment (if appropriate) f. Medications* i. Medication Allergies g. Emergency Information, including Evacuation Level** h. End of Life Preferences, including i. Health Care Directives ii. "DNR/DNI" orders iii. POLST" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	01640			

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01640	Continued From page 52 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 current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of two residents (R1, R2). In addition, the licensee also failed to ensure staff providing services were informed of the current written service plan. 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: R1 R1 was admitted to the licensee on September	01640			

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NAME OF PROVIDER OR SUPPLIER GENEROUS HOME CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3835 SARATOGA LANE NORTH PLYMOUTH, MN 55441			
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01640	Continued From page 53 20, 2023, and started receiving assisted living services. R1's diagnosis included schizophrenia. R1's Exhibit 2: Service Plan dated September 20, 2023, indicated R1 received assistance with dressing, clothing, oral care, bathing, shampoo, shaving, nail care, skin care, foot care, plate set up, verbal encouragement to eat, verbal reminders to take medication, medication administration, weekly blood pressure, shopping, clean bedroom, change linens, vacuum, dust, and laundry. R1's Home Health Aide Care Plan dated September 20, 2023, indicated R1 received clothing, oral care, haircare, bathing, plate set-up, verbal encouragement to eat, verbal reminder to take medication, medication administration, weekly blood pressure, clean kitchen, remove garbage, wash dishes, monitor foods for freshness, shopping, clean bedroom, change linens, vacuum, and dust. R2 R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received assistance with dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's Home Health Aide Care Plan dated March 13, 2023, indicated R2 received clothing, oral care, shampoo, shaving, nail care, skin care,	01640			

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01640	Continued From page 54 bathing, plate set-up, medication administration, weekly blood pressure, behavior orientation, clean kitchen, remove garbage, wash dishes, monitor foods for freshness, shopping, clean bedroom, clean bathroom, change linens, vacuum, and dust. R1 and R2's service plans were signed and dated by the registered nurse. The service plan for both residents did not include a signature or other authentication by the resident or resident's designated representative. On February 11, 2025, at 10:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the service plan form they bought from a consulting company did not provide a space for resident/resident representative or resident family signature. Therefore, LALD/CNS-C stated they did not have the residents/ resident representatives sign the service plan. GENERIC SERVICE ENTRY/LACK OF WRITTEN SERVICE PLAN INFORMATION FOR STAFF R1 and R2's records contained a generic Service Charting Sheet which indicated, "Initial activities completed. Circled initials indicate that the resident did not receive the intervention. Document reason on the back of page." The seven-day service charting sheet had AM, PM, and NOC (overnight) slots for daily charting for all of the service listed below, for both residents R1 and R2: - dressing: - clothing - hearing aide - stockings/TEDs	01640			

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01640	Continued From page 55 - braces/orthotics -hygiene: - bath - shampoo - oral care - hair care - dentures - shaving - nail care - foot care - skin care -toileting assist - incontinent pads - bowel movements - meal/plat prep (AM, Noon, PM) -exercise - prescribed -ambulation -transfer assistance -medication assistance/ MAR -vital signs: - TPR - BP - Weight - Blood glucose -behavior/orientation -treatments The identical service charting sheet for both residents lacked specifics as to which services unlicensed personnel (ULP) should provide to each resident and the frequency of the services with clear directions to implement the service plans. On February 12, 2025, at 11:31 a.m., LALD/CNS-C stated the service charting sheet had the same entry options for all residents. LALD/CNS-C further stated the ULP charted the services they provided, and would skip any service they did not provide. LALD/CNS-C stated	01640			

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01640	Continued From page 56 the ULP knew what services to provide because the nurse taught the care plans to the ULP; the care plan indicated directions for the ULP and, the ULP should ask the resident what services they needed. R2's home health aide care plan mentioned above, indicated R2 received behavior orientation services. The document also indicated to see the mental health care plan and behavioral health flowsheet. The care service charting indicated an entry for behavior/orientation. The surveyor inquired how the ULP knew what to do for the behavior/orientation entry since there was no direction for what to do or when. The surveyor requested to see the mental health care plan and behavioral health flowsheet, indicated on the home health aide care plan. On February 12, 2025, at 11:45 a.m., LALD/CNS-C stated the admission assessment form had a mental health section but the nurse who completed R2's admission assessment did not complete the mental health section. LALD/CNS-C further sated the ULP knew what to do because the nurse told them, but there was no documented direction informing the staff of the current written service plan. The licensee's Service Plans policy dated February 24, 2022, indicated the following: - the initial service plan or any revisions are signed by a representative from the licensee and the resident or the resident's representative indicating agreement with the services to be provided; - an individualized service plan is implemented for all residents and the licensee will provide all services required by the current service plan; - the service plan and all revisions are entered	01640			

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01640	Continued From page 57 into the resident's clinical record; and - the licensee will implement and provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650			

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01650	Continued From page 58 chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, 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 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: R1 R1 was admitted to the licensee on September 20, 2023, and started receiving assisted living services. R1's diagnosis included schizophrenia. R1's Exhibit 2: unsigned Service Plan dated September 20, 2023, indicated R1 received assistance with dressing, clothing, oral care, bathing, shampoo, shaving, nail care, skin care, foot care, plate set up, verbal encouragement to eat, verbal reminders to take medication, medication administration, weekly blood pressure shopping, clean bedroom, change linens, vacuum, dust, and laundry. The service plan lacked the following required content: - a contingency plan that included the following: (i) information and a method to contact the facility; - the frequency of service for the following	01650			

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01650	Continued From page 59 services: -assistance with plate set up; -assistance with verbal encouragement to eat; -assistance with verbal reminders to take medication; -assistance with medication administration; -assistance shopping; -assistance with clean bedroom; -assistance with clean bathroom; -assistance with clean kitchen; -assistance with remove garbage; -assistance with wash dishes; -assistance with monitoring foods for freshness; and -assistance with change linens. R2 R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. The service plan lacked the following required content: - a contingency plan that included the following: (i) information and a method to contact the facility. On February 11, 2025, at 10:10 a.m., assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they were aware that frequency of service was required content to be included in the service plan. LALD/CNS-C stated they might have forgotten to write frequencies for	01650			

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01650	Continued From page 60 the above listed items on R1's service plan. LALD/CNS-C further stated they bought the service plans from a consulting firm, and they trusted the consulting firm's expertise to include all the required contents in the services plan forms. The licensee's Service Plans policy dated February 24, 2022, indicated the service plan would include the following: a. description of the services that are to be provided based on the most recent assessment and resident preferences; b. fees for services to be provided; c. frequency of each service to be provided based on the most recent assessment and resident preferences; d. identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); e. schedule and method for the next planned assessment or monitoring; f. schedule and method for the next planned monitoring of staff providing services g. contingency plan that includes: i. actions to be taken if scheduled services cannot be provided; ii. information regarding how the resident can contact the licensee; iii. names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and v. circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives.	01650			

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01650	Continued From page 61 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by:	01700			

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01700	Continued From page 62 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for one of two residents (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 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: R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's medication administration record (MAR) dated February 2025, included the following: - Remind resident only. Ok to self-administer Desmopressin Acetate 0.1mg, take 1 tablet by mouth twice daily; and - triamcinolone 0.1% external ointment apply topical to affected areas two times daily at 8:00 a.m., and 8:00 p.m.	01700			

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01700	Continued From page 63 R2's individualized medication management plan (IMMP) dated March 13, 2023, indicated R2's medications were to be administered by facility staff. The IMMP did not indicate that R2 was independent for any medication administration. R2's undated Medication Management Plan indicated unlicensed personnels (ULP) and registered nurses (RN) were responsible for administering medication to R2. R2's record also included a letter written by R2's primary care provider dated June 3, 2024, which indicated, "In my opinion he is capable of administering desmopressin to himself." On February 12, 2025, at 10:50 a.m., ULP-B stated R2 kept the triamcinolone cream and the desmopressin in their room. ULP-B stated they asked R2 if they had administered the above two medications and then charted the medications based on R2's response as administered or not administered. On February 12, 2025, at 11:20 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated the IMMP mentioned above, was R2's initial IMMP. LALD/CNS-C stated they should have updated the IMMP, but they did not do it, "it is my mistake". On February 12, 2025, at 11:55 a.m., LALD/CNS-C stated they did the medication self-administration assessment for R2 for the desmopressin, but they did not document their assessment. LALD/CNS-C stated they did not know R2 was self-administering the triamcinolone cream, therefore they did not do the medication self-administration assessment for the cream.	01700			

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01700	Continued From page 64 The licensee's Coordination in the Medication Management Program policy dated February 24, 2022, indicated the agency will provide coordinated care for medication management, including a resident/family-centered and health care team-based approach to assess and meet the needs of the resident, while helping the resident to navigate effectively through the health care system related to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider's orders and	01760			

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01760	Continued From page 65 failed to reconcile provider's orders when changes were made for two of two residents (R1, 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 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: R1 R1 was admitted to the licensee on September 20, 2023, and started receiving assisted living services. R1's diagnosis included schizophrenia. R1's Exhibit 2: unsigned Service Plan dated September 20, 2023, indicated R1 received assistance with dressing, clothing, oral care, bathing, shampoo, shaving, nail care, skin care, foot care, plate set up, verbal encouragement to eat, verbal reminders to take medication, medication administration, weekly blood pressure, shopping, clean bedroom, change linens, vacuum, dust, and laundry. R1's Medication and Treatment Orders signed and dated August 5, 2024, indicated the following orders: - risperidone 2 milligrams (mg) by mouth in the morning; - risperidone 3mg by mouth at bedtime; and - risperidone 1mg by mouth up to twice daily as needed.	01760			

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01760	Continued From page 66 R1's medication administration record (MAR) dated February 2025, included the following: - risperidone 2mg tablet, give one tablet twice a day by mouth at 8:00 a.m., and 8:00 p.m.; and - risperidone 1mg tablet, give one tablet twice daily as needed by mouth for agitation. On February 10, 2025, at 11:10 a.m., the surveyor observed R1's pharmacy prepackaged medication bubble packs dispensed on January 20, 2025. The bubble packs included: - 1-risperidone 2mg tablet in the morning slots; and 1- risperidone 3mg tablet in the bedtime slots. On February 11, 2025, at 9:32 a.m., unlicensed personnel (ULP)-B stated they gave R1 2mg of risperidone in the morning and 2mg at bedtime. ULP-B stated they gave risperidone out of the pharmacy prepackaged bubble packs. The surveyor observed ULP-B look at the bubble pack again. ULP-B stated the MAR was wrong; ULP-B stated they had been giving what was prepackaged from the bubble pack which was 2mg of risperidone in the morning and 3mg at bedtime. ULP-B stated they would inform the clinical nurse supervisor (CNS) to fix the MAR to match the bubble packs. On February 11, 2025, at 3:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the correct order for R1's risperidone was accidentally deleted by the person who printed the MAR. On February 11, 2025, at 3:40 p.m., LALD/CNS-C stated they were responsible for transcribing medication orders. LALD/CNS-C further stated they reviewed medication orders every three months, but sometimes they got busy with their	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER GENEROUS HOME CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3835 SARATOGA LANE NORTH PLYMOUTH, MN 55441		
(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
01760	Continued From page 67 personal life and might have forgotten to do the medication order reviews. R2 R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's MAR dated February 2025, included the following: - hydrocortisone 5mg tablet, take two tablets by mouth in the morning at 8:00 a.m., and one tablet at 1:00 p.m.; - fluticasone Flonase spray two sprays into both nostrils daily at 8:00 a.m.; and - triamcinolone 0.1% external ointment apply topical to affected areas two times daily at 8:00 a.m., and 8:00 p.m. R2's Medication and Treatment Orders signed and dated April 16, 2024, indicated the following orders; - hydrocortisone 5mg by mouth daily; and - did not indicate orders for the fluticasone and triamcinolone 0.1% cream listed above. The MAR indicated both fluticasone inhaler and triamcinolone 0.1% cream listed above were administered to R2 as per the order on the MAR, daily from February 1, 2025, to February 9, 2025. The MAR provided two charting spaces for the hydrocortisone administration to be administered	01760			

Minnesota Department of Health

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01760	Continued From page 68 at 8:00 a.m., and at 1:00 p.m., however the MAR indicated hydrocortisone 5mg tablet, two tablets were administered daily at 8:00 a.m., from February 1, 2025, to February 9, 2025. The 1:00 p.m., administration time was left blank. On February 12, 2025, at 10:56 a.m., LALD/CNS-C stated they assumed R2 had a doctor's order for fluticasone and triamcinolone 0.1%. LALD/CNS-C stated they did medication reconciliation every month for all residents and further stated it was a transcription error. On February 12, 2025, at 10:59 a.m., LALD/CNS-C stated the hydrocortisone was supposed to be given in the morning only and that was why the 1:00 p.m., charting slot was left blank. LALD/CNS-C stated they used an after visit summary to do the monthly medication reconciliation. LALD/CNS-C stated they did not use the medication and treatment orders mentioned above because that was a form that the licensee completed manually and sent to the prescribers for signature to check if they had the same list of medication. LALD/CNS-C then provided the surveyor with R2 after visit summary below. R2's unsigned after visit summary dated May 2, 2023, indicated the following orders for the above listed medications: - hydrocortisone 5mg tablet, take two tablets by mouth in the morning at 8:00 a.m., and one tablet at 1:00 p.m.; - fluticasone Flonase spray two sprays into both nostrils daily; and - triamcinolone 0.1% external ointment apply topically two times a day to affected areas. On February 12, 2025, at 11:15 a.m.,	01760			

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01760	Continued From page 69 LALD/CNS-C stated the after-visit summary did not match the medication treatment order or the MAR, and they did not have an order to discontinue the previous order for hydrocortisone. LALD/CNS-C stated they would place a call to the provider for clarification. The licensee's Medication Orders policy dated February 24, 2022, indicated the licensee will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01760			
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were included in the assessment for medication management or documented in the resident record for one of two residents (R2). This practice resulted in a level two violation (a	01870			

Minnesota Department of Health

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01870	Continued From page 70 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: R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. R2's medication administration record (MAR) dated February 2025, included the following: - levothyroxine 100 mcg, take one tablet by mouth in daily; - hydrocortisone 5mg tablet take 2 tablet in the morning and 1 tablet at 1:00p.m., by mouth daily; - remind resident only, desmopressin 0.1mg take 1 tablet by mouth twice a day; - vitamin D 25mcg take 1 tablet by mouth in the morning; - fluticasone Flonase spray two sprays into both nostrils daily; - testosterone cypionate 200mg once every 14 days intramuscularly; - triamcinolone 0.1% external ointment apply topically to affected areas two times daily; - atorvastatin 20mg take one tablet by mouth daily	01870			

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01870	Continued From page 71 for cholesterol; - famotidine 400mg take one tablet by mouth daily for ulcer, gastroesophageal reflux; and - oxycodone 5mg every six hours as needed. R2's record included Medication and Treatment Orders signed and dated April 16, 2024, which indicated the following orders: - levothyroxine 100 mcg by mouth daily; - hydrocortisone 5mg by mouth daily; - desmopressin 0.1mg twice daily; - vitamin D 25mcg daily; - testosterone cypionate 200mg once every 14 days intramuscularly; - atorvastatin 20mg daily; - famotidine 400mg daily; and - oxycodone 5mg every six hours as needed. R2's individualized medication management plan (IMMP) dated March 13, 2023, indicated R2's medications were to be administered by facility staff. The IMMP did not indicate that R2 was independent for any medication administration. R2's undated Medication Management Plan indicated unlicensed personnels (ULP) and registered nurses (RN) are responsible for administering medication to R2. On February 11, 2025, at 10:36 a.m., the surveyor observed the following medications in R2's room: - NMN, nicotinamide mononucleotide; - Nature Made back to sleep fast acting; - Pure digest, dietary supplement; - Planetary Herbals, Mullen Lung Complex; and - Mucinex expectorant. On February 12, 2024, at 11:30 a.m., licensed assisted living director/ clinical nurse supervisor	01870			

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01870	Continued From page 72 (LALD/CNS)-C stated they were not aware of any of the medications R2 had in their room. LALD/CNS-C stated R2 never shared that they had those medications in their room. On February 12, 2024, at 1:58 p.m., unlicensed personnel (ULP)-B stated they were aware R2 had vitamins that they got from a vitamin shop in their room. ULP-B stated they did not remember if they had informed the nurse about the vitamins in R2's room. ULP-B stated they were trained that they must let the nurses know when they see medications in the resident room, but they were not aware they had to inform the nurses about residents' possession of vitamins in their rooms. The licensee's Medication Administration policy dated February 24, 2022, indicated the licensed nurse is responsible for assessing medication to assure that all medications are current and ordered by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870			
01890 SS=D	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:	01890			

Minnesota Department of Health

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01890	Continued From page 73 Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of two residents (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 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: R2 was admitted to the licensee on March 13, 2023. R2's diagnoses included functional cognitive disability, vision loss, and cerebrovascular accident. R2's Exhibit 2: Service Plan dated March 13, 2023, indicated R2 received dressing, oral care, bathing, shampoo, shaving, nail care, skin care, plate set up, verbal reminders to take medication, medication administration, weekly blood pressure, and laundry. On February 10, 2025, at 11:14 a.m., the surveyor observed the following medication for R2 in the medication cabinet located in the nurse's station on the lower level: - risperidone 1mg tablet expired on May 23, 2024; - risperidone 1mg tablet expired on June 16, 2024; - risperidone 1mg tablet expired on August 11, 2024; and - risperidone 1mg tablet expired on September 17, 2024.	01890			

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01890	Continued From page 74 On February 12, 2025, at 12:01 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were planning to discard the expired medications. The licensee's Disposition and Disposal of Medications Policy dated February 24, 2022, indicated any expired medications managed by the licensee other than controlled substance will be disposed of by a licensed nurse according to instructions provided on the drug label or the licensees procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: 02/11/25
Time: 17:00:00
Report: 8087251012

Food and Beverage Establishment Inspection Report

Page 1

Location:

Generous Home Care Services
3835 Saratoga Lane North
Plymouth, MN55441
Hennepin County, 27

Establishment Info:

ID #: 0038926
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122351680
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 0 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: REFRIDGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: REFRIDGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: REFRIDGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: REFRIDGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR DEE MOSISSA.

FLOORS AND COUNTERTOPS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE

Type: Full
Date: 02/11/25
Time: 17:00:00
Report: 8087251012
Generous Home Care Services

Food and Beverage Establishment Inspection Report

Page 2

FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

GE BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IS THE RIGHT SIDE OF THE 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR DEE MOSISSA AND TO THE ESTABLISHMENT.

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 8087251012 of 02/11/25.

Certified Food Protection Manager SUCDI M. AHMED

Certification Number: FM116950 Expires: 05/12/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

SUCDI M. AHMED
HOUSE MANAGER

Signed: _____

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