Electronically Delivered
February 16, 2022

Administrator
Gianna Homes Sursum Corda
4605 Fairhills Road East
Minnetonka, MN 55345

RE: Project Number(s) SL30827015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 6, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30827	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIANNA HOMES SURSUM CORDA	4605 FAIRHILLS ROAD EAST MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30827015 On, January 5, 2022, through January 6, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were ten (10) residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 6, 2021, at approximately 11:00 a.m.,	0 460		

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0 460	Continued From page 2 licensed assisted living director (LALD)-B and registered nurse (RN)-A acknowledged the licensee lacked a system for residents to request assistance when needed 24 hours a day. LALD-B stated staff are available to the residents at all times, and staffing ratios allow for residents' needs to be met as requested. RN-A stated most residents would not be able to appropriately use a call system due to their dementia diagnosis. The licensee lacked a policy for a system for residents to request assistance 24 hours per day, seven days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
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.	0 660		

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0 660	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document completion of a baseline tuberculosis (TB) screening at the time of hire or prior to providing services to residents for one of two employees (unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of March 19, 2019. ULP-C's record lacked evidence that a baseline TB screening had been completed at the time of hire or prior to providing services to residents. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B stated the licensee required all employees to complete a TB screening prior to providing services to residents. LALD-B stated ULP-B's screening was completed, but evidence of results are not included in ULP-B's record. LALD-B stated the result were misplaced or failed to be included in the employee's record. The licensee's TB Prevention and Control policy, dated July 26, 2021, indicated at time of hire and prior to any contact with residents, all assisted living employees and all volunteers will be screened for tuberculosis. The policy also stated	0 660		

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0 660	Continued From page 4 the licensee will maintain all reports of TB screening in the personnel files of assisted living employees and volunteers. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 5 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify unique or unusual resident needs for movement or evacuation. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 06, 2022, at approximately 1:40 p.m., the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, if available. Upon review the following items were not documented: 1. No written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. Licensed assisted living director (LALD-B) confirmed documentation of fire safety and	0 810		

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0 810	Continued From page 6 evacuation policy and procedures were incomplete. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving	01370		

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01370	Continued From page 7	01370		

the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;
(12) awareness of confidentiality and privacy;
(13) understanding appropriate boundaries between staff and residents and the resident's family;
(14) procedures to use in handling various emergency situations; and
(15) awareness of commonly used health technology equipment and assistive devices.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to complete the required training and competency testing for one of one unlicensed personnel ((ULP)-D) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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:

During an observation on January 6, 2022, at approximately 6:30 a.m., ULP-D propelled R1 in a wheelchair without footrests in place. R1 held their feet slightly off the floor as ULP-D pushed R1 to the dining area for breakfast.

R1 admitted to the licensee on January 4, 2021. R1's diagnoses included dementia, Parkinson's

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01370	Continued From page 8 disease, Type 2 diabetes mellitus, and hypertension. R1's 14-90-Change of Condition Assessment, dated October 13, 2021, indicated R1 was independent for mobility and ambulation. The assessment also indicated R1 utilized a walker and a wheelchair. On January 6, 2022, at approximately 7:00 a.m., ULP-D stated they were trained by the registered nurse (RN) on assistive devices, but did not recall being trained on use of footrests on wheelchairs. On January 6, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-B and RN-A stated R1 is usually independent with their wheelchair and does not use footrests as they use their feet to propel themselves. LALD-B stated training for employees on wheelchairs is limited to transfers, but no training on mobility with wheelchairs was covered. RN-A stated the training on wheelchairs did not address placing footrests in place when pushing residents in them. LALD-B and RN-A acknowledged training on the use of footrests for all wheelchairs should be included in their training programs. The licensee lacked a policy to address the use of wheelchairs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be	01480		

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01480	Continued From page 9 oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: ULP-C had a hire date of December 3, 2021. ULP-C's record lacked evidence of orientation to each specific resident and the services to be provided. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and RN-A acknowledged evidence of orientation to clients was lacking from all employee and resident records. LALD-B stated the licensee was working with their electronic health record service provider to develop a system to address this, but no system had been developed or implemented at the time of the survey.	01480		

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01480	Continued From page 10 The licensee's Staff Orientation to Individual Client policy, dated July 26, 2021, stated staff providing services will be oriented specifically to each individual resident and the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01620 SS=F	144G.70 Subd. 2 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.	01620		

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01620	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on January 4, 2021. R1's diagnoses included dementia, Parkinson's disease, Type 2 diabetes mellitus, and hypertension. R1's 14-90-Change of Condition Assessment, dated October 13, 2021, lacked areas of the uniform assessment tool that included the resident's personal lifestyle preferences, instrumental activities of daily living, emotional and mental health conditions, list of treatments, risk indicators, who has decision-making authority for the resident, and the need for follow-up referrals for additional medical or cognitive care by health professionals. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and RN-A acknowledged assessments for residents	01620		

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01620	Continued From page 12 lacked all areas required on the uniform assessment tool. RN-A stated the current form used for all residents lacked the required areas on uniform assessment tool. RN-A identified R1's 14-90-Change of Condition Assessment, dated October 13, 2021, as R1's comprehensive assessment. LALD-B stated the electronic health record program licensee utilized would need to be updated to address the required areas on the uniform assessment tool as currently it lacked many areas required. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy, dated July 26, 2021, identified all required areas on the uniform assessment tool to be completed with each nursing assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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:	01650		

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01650	Continued From page 13 (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 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 6, 2022, at approximately 6:30 a.m., unlicensed personnel (ULP)-D provided services to R1 including: assistance to get dressed, transferred to a wheelchair, combed hair, brushed teeth, provided breakfast, applied T.E.D.	01650		

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01650	Continued From page 14 Hose (anti-embolism or compression stockings) to both lower legs, and administered medications as ordered by the provider. R1 admitted to the licensee on January 4, 2021. R1's diagnoses included dementia, Parkinson's disease, Type 2 diabetes mellitus, and hypertension. R1's signed service plan, dated August 23, 2021, indicated R1 received activities of daily living, meals, assistance with ambulation, and toileting services. R1's service plan lacked identification of medication management services, treatment management services, and the schedule and method of monitoring of staff that provided services. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A acknowledged R1's service plan lacked identification of medication management and treatment management services. LALD-B stated the services were part of living in the licensee's facility and all residents would have those services provided. LALD-B stated the licensee had not included those services on the service plan as they were all covered in the cost to live in the licensee's facility. LALD-B acknowledged there was not a schedule or method of monitoring of staff that provided services, as the licensee was not aware of the requirement. RN-A stated that staff monitoring occurs regularly, and ongoing training is provided, but is not included on the service plan. The licensee's Contents of Service Plans policy, dated July 26, 2021, indicated the service plan will include a description of the services provided and the schedule and methods of monitoring staff	01650		

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01650	Continued From page 15 providing services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

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01790	Continued From page 16 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one unlicensed personnel (ULP)-C with record reviewed. This practice resulted in a level two violation (a	01790		

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01790	Continued From page 17 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C had a hire date of March 19, 2019. ULP-C's record lacked documentation of training and competencies for unplanned time away when the RN is not available. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and RN-A acknowledged ULP-C's record lacked documentation of training and competencies for unplanned time away when the RN is not available. RN-A stated ULPs are provided information about unplanned time away during their initial medications training, but no competencies are administered or maintained in the employee records. RN-A stated the policy indicated ULPs are to call the on-call nurse and receive instructions on setting up medications for the residents if the situation occurred. The licensee's Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away from Home policy, dated July 26, 2021, indicated only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medication prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medications.	01790		

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01790	Continued From page 18 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a current individualized treatment and therapy management record with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 6, 2022, at approximately 6:30 a.m., ULP-D applied T.E.D. Hose (anti-embolism or compression stockings) to both of R1's lower legs. ULP-D stated they were trained by licensee's registered nurse (RN) on proper application and would contact the RN if any problems arose. ULP-D stated the training to contact a RN was provided during orientation prior to being able to provide services to residents. R1 admitted to the licensee on January 4, 2021. R1's diagnoses included dementia, Parkinson's disease, Type 2 diabetes mellitus, and hypertension. R1's Medication and Treatment/Therapy Management Plan, dated October 19, 2021, indicated medication and treatment/therapy tasks that may be delegated to the ULPs are located on	01940		

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01940	Continued From page 20	01940		

the medication administration record (MAR) or on the "Service Tasks." The plan, identified by RN-A as R1's individualized treatment and therapy management record, lacked written instructions for a prescribed treatment and procedures for notifying a RN or health care professional when problems arose with the treatment.

R1's Medication Set-Up Sheet, dated January 2022 and identified by RN-A as R1's MAR, instructed ULPs to apply T.E.D. Hose every morning to R1's bilateral lower legs, remove at bedtime, rinse, and hang to dry.

R1's Service Plan, dated August 23, 2021, identified by RN-A as the "Service Tasks," lacked identification of the treatment management plan.

On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and RN-A acknowledged R1's individualized treatment and therapy management record lacked specific instructions and a procedure for notifying a RN or licensed health professional if problems would arise. RN-A stated all ULPs are trained to contact the RN immediately if there are problems but acknowledge R1's record lacked the specific instructions for application of the T.E.D. Hose and indications when the ULPs should contact the RN.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated July 26, 2021, indicated the RN may delegate to ULPs the task of providing assistance with administration of medications, treatment and therapy if the ULPs have satisfied the training requirements listed above and if: the RN has developed written, specific instruction for each client. The licensee lacked a process for the

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01940	Continued From page 21 ULPs to contact the RN or licensed health professional when a problem arose. The policy also lacked specific information regarding management of a treatment or therapy plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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	02040		

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02040	Continued From page 22 or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 06, 2022, from approximately 1:00 p.m. to 1:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD-B). During the facility tour, survey staff observed an outdoor fountain, gas fireplace, and wheelchair lift. LALD-B stated that the fountain had been turned off for over a year due to recent drought conditions, the gas fireplace had been disconnected so it would not be a risk of burning, and the call button for the wheelchair lift had been disabled from the lower level so that residents on the upper level could not call it without supervision. Survey staff stated that those are all examples that should be documented on the facility hazard vulnerability assessment. The licensee is currently mitigating local hazards but is missing the documentation. Review of Hazard Vulnerability Assessment showed global issues such as pandemic, flood, power outage, etc. but did not include local hazards such as the facility's outdoor fountain, indoor fireplace, and wheelchair lift. During the interview on January 06, 2022, at 1:40 p.m., LALD-B stated she will survey the facility again and document any additional hazards and the mitigation strategy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02110	Continued From page 23	02110		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on January 4, 2021. R1's diagnoses included dementia, Parkinson's disease, Type 2 diabetes mellitus, and hypertension. R1's record lacked documentation of receipt of required policies and procedures to be provided at the time of move-in. On January 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B acknowledged the policies were available to the residents and/or the resident representatives, but the policies were not provided to each resident and/or resident's representative at the time of move-in. The Determination of Scope of Agency Services and Development of Written Materials for Communication with Clients policy, dated November 29, 2021, lacked identification of required policies and procedures to be provided to residents at move-in.	02110		

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02110	Continued From page 25 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *01/05/22*
Time: 10:00:00
Report: 8041221002

Food and Beverage Establishment Inspection Report

Location:
Gianna Homes Sursum Corda
4605 Fairhills Road East
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0039382
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529880953
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 171 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: lower level cooler: lettuce
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: lower level cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: kitchen cooler: yogurt
Violation Issued: No

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

Inspection was completed with the Executive Director, Cari Doucette. Brandon Mueller (lead RN evaluator - HRD) was also present completing site survey.

Lunch is received frozen from Lets Dish. Food is prepared for same day service only. All food service equipment is ANSI except for the crockpot, which may be used if cooking/re-heating time & temperature requirements are in compliance with the MN food code. Fact sheet sent with report.

Discussed the following:

Handwashing
Glove-use and bare hand contact
Thermometer use and calibration
Date marking
Employee illness policy and logging requirements

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 8041221002 of 01/05/22.

Certified Food Protection Manager: Cari Niemi Doucette

Certification Number: fm103694 Expires: 07/15/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Cari Doucette
Ex. Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
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