October 11, 2023

Licensee
Gianna Homes Gladys' Place, LLC
10210 28th Avenue North
Plymouth, MN 55441

RE: Project Number(s) SL30018015

Dear Licensee:

On September 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 3, 2023, survey were corrected. This follow-up survey verified that the facdility 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,

Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

Electronically Delivered

August 8, 2023

Licensee
Gianna Homes Gladys' Place, LLC
10210 28th Avenue North
Plymouth, MN 55441

RE: Project Number(s) SL30018015

Dear Licensee:

On July 27, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 3, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 3, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on May 3, 2023, found not corrected at the time of the July 27, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on July 27, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

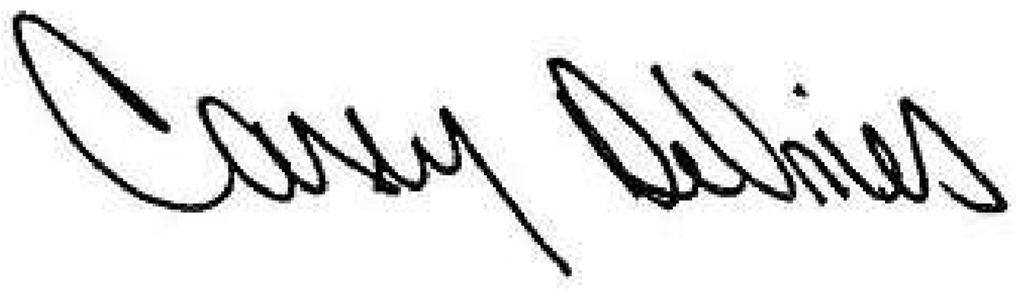
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30018	A. BUILDING: _____ B. WING _____	R 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIANNA HOMES GLADYS' PLACE LLC	10210 28TH AVENUE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30018015-1 On July 27, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 03, 2023. At the time of the survey, there were 5 residents: 5 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}		
{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;	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810}	Continued From page 1 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No additional action required.	{0 810}		
{0 820} SS=C	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use	{0 820}		

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{0 820}	Continued From page 2 does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical facility elements did not constitute a distinct hazard to life. The licensee had door lock hardware that required a code to exit the home on the egress side of all the doors leading outside. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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: On July 27, 2023, from approximately 10:00 a.m. to 11:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. It was observed that the exit door out of the facility was still locked with a keypad that required a code to open it. Survey staff verified with LALD-A	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIANNA HOMES GLADYS' PLACE LLC	10210 28TH AVENUE NORTH PLYMOUTH, MN 55441

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{0 820}	Continued From page 3 that the lock was not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position if the power went out. Survey staff explained to LALD-A that the lock in the path of egress that required a code would cause a delay in the proper exiting of the space during a fire or similar emergency. LALD-A visually verified these deficient findings at the time of discovery. LALD-A stated that she was working with her security vendor to find an appropriate solution to the door locks, but had not heard anything back by the time of the follow-up survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 820}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No additional action required.	{0 970}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 19, 2023

Licensee
Gianna Homes Gladys' Place, LLC
10210 28th Avenue North
Plymouth, MN 55441

RE: Project Number(s) SL30018015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

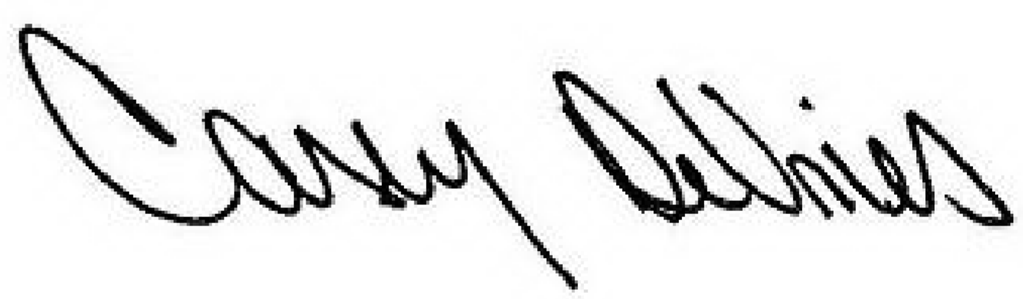
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30018	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIANNA HOMES GLADYS' PLACE LLC	10210 28TH AVENUE 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: SL30018015-0 On May 1, 2023, through May 3, 2023, 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 five residents receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on May 03, 2023, issued for SL30018015-0, tag identification 0820. On May 03, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of H.	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 with Dementia Care facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 780	Continued From page 2 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). Findings include: On a facility tour on May 03, 2023, from approximately 11:30 a.m. to 12:15 p.m. with Licensed Assisted Living Director (LALD)-A it was observed that a smoke alarm was not installed outside and in the immediate area of bedrooms #2 and #3 as required by statute. LALD-A verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 800	Continued From page 3 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, 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). Findings include: On a facility tour on May 03, 2023, from approximately 11:30 a.m. to 12:15 p.m. with the Licensed Assisted Living Director (LALD)-A, it was observed that all the bedroom windows had the casement hardware crank removed. Egress windows must be provided and properly maintained in buildings not equipped with an automatic sprinkler system LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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;	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 4 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills. This 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, but was not likely to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 5 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). Findings include: A record review and interview were conducted on May 03, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not have a policy	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30018	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIANNA HOMES GLADYS' PLACE LLC	10210 28TH AVENUE 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
0 810	Continued From page 6 on training employees on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated the licensee did not have a policy on training employees. Record review of the available documentation indicated that the licensee did not have a policy on offering training on the fire safety and evacuation plan to residents who can assist in their own evacuation. During interview, LALD-A stated that the facility did not have a policy on offering resident training on the fire safety and evacuation plan, and stated that the current residents were not capable of assisting in their own evacuation. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were completed only on the first shift and did not include second or third shift. Licensee did not have a policy on evacuation drills. During interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	0 820		

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0 820	Continued From page 7 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms # 1 and #4 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedroom #1 on the main floor and #4 on the upper floor. 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, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 03, 2023, approximately from 11:30 a.m. to 12:15 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. At approximately 11:45 a.m., survey staff asked LALD-A to open the window in occupied resident bedroom #1 on the main floor for measurement.	0 820	Response to the 5/3/2023 Gianna Homes Gladys Place 0 820 Fire protection and physical environment Immediate Corrective Action - see below: Gianna Homes Gladys Place Correction Action Plan: LALD and RN Case Manager Immediately developed and implemented a Firewatch program for staff/resident and home. The Firewatch program includes hourly checks on the resident room (Room #1 and Room #4). This Firewatch program will be done hourly 24/7 until a repair or replacement has been made. Please see attached Firewatch hourly check documentation. All staff will be trained and educated on the definition of a Firewatch and the steps needed to ensure safety. All Staff will sign off on this training to ensure compliance with this corrective action. Please see attached Firewatch training documentation for staff.	

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0 820	Continued From page 8 LALD-A opened the casement-style window, and the survey staff measured the clear opening to be 16 inches in width. The opening was obstructed by the windowpane due to how the crank hardware and arm moved the window. In the closed position the clear width measured 20 inches, but when opened the clear opening width was reduced significantly. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. At approximately 12:00 p.m., survey staff asked LALD-A to open the window in occupied resident bedroom #4 on the upper floor for measurement. LALD-A stated that she did not need to open the window because it was the same size as the window in bedroom #1 on the main floor. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20" and minimum openable height of 20" with no less than 648 square inches total of openable area (4.5 square feet) for the window. On the same facility tour, it was observed that the exit door out of the facility was locked with a keypad that required a code to open it. Survey staff verified with LALD-A that the lock was not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position if the power went out. Survey staff explained to LALD-A that the lock in the path of egress that required a code would cause a delay in the proper exiting of the space during a fire or similar	0 820	LALD will immediately consult with maintenance person to begin steps of correcting window openings to meet the 20¡¨ requirements with no less than 648 square inches total openable area (4.5 sq ft) for the window. In addition, LALD will consult with outside providers to explore options for window replacement/repair. LALD will update MDH immediately when repair or replacement is completed for inspection. Completed by: Cari Doucette, LALD and Kate Skorseth, RN Case Manager Gianna Homes Gladys Place 5/3/2023	

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0 820	Continued From page 9 emergency. LALD-A visually verified these deficient findings at the time of discovery. On May 03, 2023, at approximately 12:30 p.m., at the exit interview, survey staff explained to LALD-A that an immediate correction order was issued for the undersized egress windows. LALD-A acknowledged the above finding. On May 03, 2023, at 2:33 p.m. the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of H. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident (R2). This had the potential to affect all residents living at the facility.	0 970		

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0 970	Continued From page 10 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: R2's Service Plan Agreement effective August 8, 2022, included assistance with transfers, ambulation, bathing, dressing, grooming, medication administration, vital signs, laundry, housekeeping, toileting, record meal intake, record bowel movements, monitor skin condition, safety checks, and evacuation assistance. R2's Assisted Living Contract effective August 4, 2022, included the following language indicating a waiver of liability on Page 9, section 8 "Personal Property." "Resident shall at all times be responsible for the safekeeping of his/her personal property and Resident is advised to maintain a policy of insurance covering loss or damage to his/her personal property. Gianna Homes Gladys Place shall not be liable under any circumstances for damage to or loss of Resident's personal property. Resident is advised not to keep valuable personal property in his/her suite or in common areas. Resident's personal property must be removed from the property when Resident ceases to reside in the community. Personal property not removed when Resident leaves the community will be disposed of and we may charge you the costs of disposing said items." On May 2, 2023, at 11:00 a.m., surveyor reviewed	0 970		

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0 970	Continued From page 11 licensee's blank Assisted Living contract. Licensee's blank Assisted Living contract included the following language indicating a waiver of liability on Page 9, section 8 entitled, "Personal Property": "Resident shall at all times be responsible for the safekeeping of his/her personal property and Resident is advised to maintain a policy of insurance covering loss or damage to his/her personal property. Gianna Homes Gladys Place shall not be liable under any circumstances for damage to or loss of Resident's personal property. Resident is advised not to keep valuable personal property in his/her suite or in common areas. Resident's personal property must be removed from the property when Resident ceases to reside in the community. Personal property not removed when Resident leaves the community will be disposed of and we may charge you the costs of disposing said items." On May 2, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee's assisted living contract included a waiver of liability for resident's health and safety or personal property, and that the same contract was given to all residents of the facility. LALD-A stated the licensee's lawyers drafted their contract and agreed the language should not have been in the contract. LALD-A stated the language currently used in licensee's contract would be removed. Licensee's policy Content of Resident Records dated April 1, 2023, did not include any reference to omit language waiving the licensee's liability for health, safety, or personal property of a resident in their contract. No further information was provided.	0 970		

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0 970	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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

Type: Full
Date: *05/02/23*
Time: 10:30:00
Report: 1013231124

Food and Beverage Establishment Inspection Report

Location:

Gianna Homes Gladys' Place Llc
10210 28th Avenue North
Plymouth, MN55441
Hennepin County, 27

Establishment Info:

ID #: 0039123
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524436110
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Potato salad
Temperature: 37 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Pasta salad
Temperature: 39 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Vegetables
Temperature: 27 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Garage refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Garage refrigerator
Violation Issued: No

Type: Full
Date: *05/02/23*
Time: 10:30:00
Report: 1013231124
Gianna Homes Gladys' Place Llc

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator R. Makela.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, fiberglass reinforced panel walls, solid counter top, and a painted ceiling. The kitchen finishes and surfaces were well maintained. The kitchen refrigerator and freezer are commercial and ANSI certified.

A designated hand washing sink is located in the kitchen. The hand washing sink was supplied with soap and paper towels.

A residential dish machine is located in the kitchen.

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231124 of 05/02/23.

Certified Food Protection Manager: Cari Doucette

Certification Number: 103694 Expires: 07/15/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Cari Doucette
Operator

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