



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 26, 2025

Licensee
Gondola Group Inc.
4307 159th Court West
Rosemount, MN 55068

RE: Project Number(s) SL25861016

Dear Licensee:

On March 6, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 17, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 7, 2025

Licensee
Gondola Group Inc.
4307 159th Court West
Rosemount, MN 55068

RE: Project Number(s) SL25861016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25861016-0 On December 16, 2024, through December 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility license. An immediate correction order was identified on December 17, 2024, issued for SL25861016-0, tag identification 0780. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 550	Continued From page 1 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: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current 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 December 16, 2024, at 10:00 a.m. during the	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 550	Continued From page 2 facility tour with licensed assisted living director (LALD)-A, the surveyor observed the licensee's grievance procedure posted on the main bulletin board. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the posting lacked the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On December 17, 2024, at 12:08 p.m., LALD-A reviewed the posted grievance procedure and stated it did not include the name, telephone number, and email contact for the individuals who were responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
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	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 660	Continued From page 3 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a current facility TB risk assessment. 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 December 16, 2024, at approximately 9:30 a.m. during the entrance conference, the surveyor requested the current facility TB risk assessment. The facility's TB risk assessment dated January 25, 2022, was provided. On December 17, 2024, at 12:10 p.m., owner (O)-B reviewed the facility's TB risk assessment and stated it should have been updated annually. The licensee's Infection Prevention and Control	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 660	Continued From page 4 policy dated January 25, 2022, indicated staff would complete a TB assessment worksheet yearly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 680	Continued From page 5 by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of 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 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 undated, Emergency Preparedness plan was reviewed and lacked the following: - documented risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans); - exercises conducted to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; an additional annual exercise conducted that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 680	Continued From page 6 exercise On December 17, 2024, at 12:15 p.m., licensed assisted living director (LALD)-A stated the licensee's current EP plan did not include the above content. The licensee's Emergency Preparedness Program policy dated January 1, 2024, indicated the facility staff would participate in a full-scale exercise that is community -based, or when a community-based exercise was not accessible, an individual, facility-based tabletop exercise. The facility would also conduct an additional annual exercise that may include, but not limited to a second full-scale exercise that is community-based or individual, facility-based or a tabletop exercise that included a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed message, or prepared questions designed to challenge and emergency plan or a mock disaster drill. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=H	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;	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 780	Continued From page 7 (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 resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code. Based on observation and interview, the licensee failed to provide required egress windows in resident sleeping rooms in compliance with Minnesota State Fire Code, MN Rules Chapter 7511. This had the potential to affect a portion residents, staff, and visitors. 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).	0 780	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
0 780	Continued From page 8 The findings include: On November 17, 2024, from approximately 9:48 a.m. to 11:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and owner (O)-B. During the tour, the surveyor asked LALD-A to open the windows in the resident sleeping rooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 1: One window measuring 17 inches clear width, 41 inches clear height, and 697 square inches total openable area. Resident sleeping room 2: One window measuring 17 inches clear width, 41 inches clear height, and 697 square inches total openable area. The windows in resident sleeping rooms 1, and 2 did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to LALD-A and O-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On December 17, 2024, the surveyor explained to LALD-A and O-B that an immediate correction	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
0 780	Continued From page 9 order was issued for the above findings. LALD-A and O-B stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. The smoke alarm in resident sleeping room 4 was not interconnected with other provided smoke alarms throughout the facility. When other alarms were tested, the smoke alarm in resident room 4 did not sound an alarm. Activation of any one alarm must cause all alarms to operate. Burnt cigarettes were found in significant number along sides of front driveway of property. Cigarette butts were not properly disposed of in an approved receptacle. A multiplug adapter was utilized for electronic devices in resident sleeping room 2 which was not properly listed as fire safe in compliance with requirements of Minnesota State Fire Code. TIME PERIOD FOR CORRECTION: Immediate.	0 780			
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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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 10 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with required content. 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:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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 11 On December 17, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A and owner (O)-B provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP did not include the identification of unique or unusual resident needs for evacuation. The FSEP did not include in the evacuation plan any procedures for a supplied chair lift on stairs to basement level, which may obstruct egress during evacuation. FSEP evacuation procedures should address proper storage and plans for egress around stair lift. The FSEP identified the garage as a marked exit. The garage may not be utilized as a marked exit as it is classified as an area of higher hazard. During the record review and interview on December 17, 2024 LALD-A and O-B verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01370 SS=D	144G.61 Subd. 2 (a) 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	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01370	Continued From page 12 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 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 interview and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-D) to include all	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01370	Continued From page 13 required content. 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-D was hired on June 6, 2020, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of training for the following topics: -reports of changes in resident's condition to the supervisor designated by the facility: -basic infection control, including blood-borne pathogens; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. ULP-D's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01370	Continued From page 14 On December 17, 2024, at 11:34 a.m., licensed assisted living director (LALD)-A stated ULP-D was trained and competent in all areas listed above; however, ULP-D's record lacked evidence of the training and competency evaluations. The licensee's Staff Competency Evaluations policy dated January 9, 2024, indicated training and evaluation of unlicensed personnel must include: 2. Reports of changes in the resident's condition to the supervisor designated by the facility. 3. Basic infection control, including blood-borne pathogens 5. Appropriate and safe techniques in personal hygiene and grooming, including: a. Hair care and bathing b. Care of teeth, gums, and oral devices c. Care and use of hearing aids d. Dressing and assistance with toileting 7. Standby assistance techniques and how to perform them 11. Communication skills that include preserving the dignity of the resident and showing respect for the resident and resident's preferences, cultural background, and family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01380	Continued From page 15 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-D) to include all required content. 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-D was hired on June 6, 2020, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluation for the following topics: -reading and recording temperature, pulse, and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01380	Continued From page 16 respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning. On December 17, 2024, at 11:34 a.m., licensed assisted living director (LALD)-A stated ULP-D was trained and competent in all areas listed above; however, ULP-D's record lacked evidence of the training and competency evaluations. The licensee's Staff Competency Evaluations policy dated January 9, 2024, indicated training and evaluation of unlicensed personnel must include: 18. Reading and recording temperature, pulse, and respirations of the resident 20. Safe transfer techniques and ambulation 21. Range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01440	Continued From page 17 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of two 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, 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-E was hired on October 14, 2023, to provide direct care and services to the facility's residents. On December 17, 2024, at 11:41 a.m., licensed assisted living director (LALD)-A stated ULP-E's employee record lacked evidence of a 30-day supervision of a delegated task by the RN.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01440	Continued From page 18 The licensee's Delegation of RN Services policy dated January 15, 2022, indicated the RN would assure that training and competency records for all unlicensed staff are kept up-to date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01460	Continued From page 19 was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) completed an orientation to assisted living facility licensing requirements and regulations before providing services to 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 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 October 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01460	Continued From page 20 services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license On December 17, 2024, at 11:40 a.m., owner (O)-B stated ULP-E had not completed orientation to assisted living facility requirements as listed above. The licensee's Staff Orientation and Training policy dated January 8, 2024, indicated new employees would complete the following orientation training: -Complete staff orientation and training form along with orientation binder. -Vulnerable adult -Minnesota bill of rights -Facility policies and procedures -Safety in the workplace -Emergencies -Grievance policy and procedure -HIPAA and Data Privacy -COVID -Core Training and Medication Administration by RN -Safe and correct operation of medication equipment by RN -Supervised on job training -Person centered thinking -Age related hearing loss -Food handling	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01460	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01460			
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 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01500	Continued From page 22 (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: (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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D and 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, 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01500	Continued From page 23 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired on June 6, 2020, to provide direct care and services to the facility's residents. On December 17, 2024, at 7:00 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - reporting of maltreatment of vulnerable adults under section 626.557; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person ULP-E ULP-E was hired on October 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence the employee had successfully completed annual	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01500	Continued From page 24 training as required, to include the following: - 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; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On December 17, 2024, at 11:40 a.m., owner (O)-B stated ULP-D and ULP-E had not completed the required annual training as listed above. The licensee's Staff Orientation and Training policy dated January 8, 2024, indicated an employee would have a minimum of eight hours per year of training. All training would be recorded for each employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
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	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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 25 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 one of two employees (unlicensed personnel (ULP)-E) received the required amount of dementia care training in the required time frame. 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:	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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 26 The licensee provided services under an Assisted Living license. ULP-E was hired on October 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of completing any dementia care training. On December 17, 2024, at 11:39 a.m., owner (O)-B stated ULP-E had not completed the required dementia care training. The licensee's Staff Orientation and Training policy dated January 8, 2024, indicated employees would complete Alzheimer's disease/dementia care training as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=D	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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 27 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 nursing assessments not to exceed 90 days for one of one resident (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 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: R1 was admitted on January 22, 2024, with diagnoses that included diabetes. R1's service plan dated September 24, 2024, indicated R1 received assistance with bathing, walking, housekeeping, laundry, meals, and medication administration.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 28 R1's ongoing nursing assessments were requested. Assessments dated May 5, 2024, August 4, 2024, and October 22, 2024, were provided. The August 4, 2024, assessment was done 91 days after the date of the previous assessment, thus exceeding 90 calendar days. On December 17, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated R1's August assessment exceeded 90 days from the previous assessment. The licensee's Nursing Assessment policy dated January 8, 2024, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	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	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01640	Continued From page 29 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (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 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: R1 was admitted on January 22, 2024, with diagnoses that included diabetes. R1's service plan dated September 24, 2024, indicated R1 received assistance with bathing, walking, housekeeping, laundry, meals, and medication administration. The service plan did	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01640	Continued From page 30 not include blood sugar checks. R1's signed prescriber orders dated January 25, 2024, included: -test blood sugar one time a day as directed. On December 17, 2024, at 11:23 a.m., owner (O)-B stated R1's service plan did not include blood sugar checks. The licensee's Service Plan policy dated January 8, 2024, indicated the service plan would include all services provided. 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	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01650	Continued From page 31 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 interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (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) 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 was admitted on January 22, 2024, with diagnoses that included diabetes. On December 17, 2024, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated September 24, 2024, indicated R1 received assistance with bathing, walking, housekeeping, laundry, meals, and medication administration.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01650	Continued From page 32 R1's service plan lacked the following content: - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 an information as to who has authority to sign for the resident in and emergency; and 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. On December 17, 2024, at 12:00 p.m., owner (O)-B stated R1's service plan did not include the required content as listed above. O-B further stated the same service plan template was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01750	Continued From page 33 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of one resident (R1) whose medication administration was delegated to unlicensed personnel (ULP). 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: R1 was admitted on January 22, 2024, with diagnoses that included diabetes. On December 17, 2024, at 7:00 a.m., the surveyor observed ULP-D administer medications to R1. R1's service plan dated September 24, 2024, indicated R1 received assistance with medication administration.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01750	Continued From page 34 R1's Medication Administration Record (MAR) dated December 2024, included the following order: -cyclobenzaprine hydrochloride 5 milligrams (mg); take one to two tablets by mouth every eight hours as needed for muscle spasms. R1's record lacked prescriber orders for cyclobenzaprine hydrochloride. The licensee failed to have resident-specific instructions regarding when one tablet or two tablets of cyclobenzaprine hydrochloride would be given. On December 17, 2024, at 11:19 a.m., clinical nurse supervisor (CNS)-C stated there were no specific instructions regarding the dose for R1's cyclobenzaprine hydrochloride order and would follow up with R1's provider. The licensee's Documentation of Medication, Treatment and Therapy policy dated February 14, 2024, indicated the registered nurse would provide specific instructions for administer PRN (as needed) medications, treatments, and therapy consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup,	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01770	Continued From page 35 name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: During the entrance conference on December 16, 2024, at approximately 9:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to their residents, including medication set up. R3 was admitted on October 23, 2021, with diagnoses that included chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow and makes it difficult to breathe). R3's signed prescriber orders dated January 3, 2024, included: -guaifenesin-codeine 100-10 milligram (mg)/5 milliliter (ml) solution; Take 5 ml by mouth every	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01770	Continued From page 36 four hours as needed for cough. On December 16, 2024, at 10:46 a.m., R3 requested PRN (as needed) cough syrup. The surveyor observed unlicensed personnel (ULP)-D remove a large Ziplock bag with pre-filled syringes in it from the locked narcotic drawer in the medication cart. Written on the Ziplock bag was R3's name and the name of the medication (guaifenesin-codeine). ULP-D removed one syringe from the bag and emptied the contents of the unlabeled syringe into a medication cup and administered it to R3. R3's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On December 17, 2024, at 10:14 a.m., clinical nurse supervisor (CNS)-C stated R3's cough syrup was set up into pre-filled syringes as it made it easier for tracking the doses administered since it was a narcotic. CNS-C further stated she did not document the set up anywhere in R3's record. The licensee's Medication Setup policy dated January 8, 2024, indicated the nurse would document medication setup in the resident's electronic health record. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01790	Continued From page 37 (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 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	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01790	Continued From page 38 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 two of two unlicensed personnel (ULP)-D and ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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:	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01790	Continued From page 39 ULP-D ULP-D was hired on June 6, 2020, to provide direct care and services to the facility's residents. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-E ULP-E was hired on October 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On December 17, 2024, at 7:39 a.m., owner (O)-B stated all ULP were trained and competency tested on providing medications to residents for unplanned time away, but there was no documentation of the training or competencies. The licensee's Medication Management for Residents Away from Home policy dated January 8, 2024, indicated the facility would provide the necessary medications, education, instructions, and support to meet the resident's medication needs when they are away from home. Only unlicensed staff that have been trained and have satisfactory demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of one resident (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) 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: R1 was admitted on January 22, 2024, with diagnoses that included diabetes. On December 17, 2024, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated September 24, 2024, indicated R1 received assistance with medication administration. The service plan did not include blood sugar checks. AMLODIPINE BESYLATE:	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01820	Continued From page 41 R1's Medication Administration Record (MAR) dated December 2024, included the following medications: -amlodipine besylate 2.5 milligrams (mg); take one tablet by mouth daily with a 5 mg tablet (total dose 7.5 mg) -amlodipine besylate 5 mg; take one tablet by mouth daily with a 2.5 mg tablet (total dose 7.5 mg) R1's record lacked prescriber orders for amlodipine besylate. BREYNA INHALER: -R1's MAR dated December 2024, included Breyna 80-4.5 micrograms (mcg) HFA; inhale two puffs orally twice a day as needed. -R1's prescriber orders dated January 18, 2024, included Breyna 80-4.5 micrograms (mcg) HFA; inhale two puffs orally twice a day scheduled. R1's record lacked an order to administer Breyna inhaler twice a day as needed instead of twice a day scheduled. ACETAMINOPHEN: -R1's MAR dated December 2024, included acetaminophen 500 mg; give one tablet once a day as needed for pain level 1-5, give two tablets once a day as needed for pain level 6-10. -R1's prescriber orders dated January 18, 2024, included acetaminophen 325 mg; give 650 mg by mouth every four hours as needed for pain. R1's record lacked prescriber orders to discontinue the acetaminophen 325 mg dose and an order to start acetaminophen 500 mg dose. LISINOPRIL: -R1's MAR dated December 2024, include lisinopril 20 mg; take one tablet by mouth daily -R1's prescriber orders dated January 18, 2024, included lisinopril-hydrochlorothiazide 20-25 mg;	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01820	Continued From page 42 give one tablet by mouth once a day R1's record lacked a prescriber order to discontinue lisinopril-hydrochlorothiazide 20-25 mg and an order to start lisinopril 20 mg. METFORMIN: -R1's MAR dated December 2024, included metformin 500 mg; take two tablets (=1,000 mg) by mouth two times a day -R1's prescriber orders dated January 18, 2024, included metformin 500 mg; take one tablet by mouth two times a day R1's record lacked an order to administer 1,000 mg of metformin twice a day. OMEPRAZOLE: -R1's MAR dated December 2024, included omeprazole 20 mg; take one capsule by mouth twice a day -R1's prescriber orders dated January 18, 2024, included omeprazole 20 mg; take one capsule by mouth once a day R1's record lacked a prescriber order to administer omeprazole twice a day. ONDANSETRON: -R1's MAR dated December 2024, included ondansetron 4 mg; take one tablet by mouth every eight hours as needed for nausea. -R1's prescriber orders dated January 18, 2024, included ondansetron 4 mg; take one tablet by mouth every four hours as needed for nausea. R1's record lacked a prescriber order to administer ondansetron every eight hours instead of every four hours as needed. R1's MAR dated December 2024, included the following medications: -Fiber Adult Gummies 4 grams (g); take two gummies by mouth daily.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01820	Continued From page 43 -hydroxyzine 25 mg; take one half tablet (=12.5 mg) by mouth twice a day -Jardiance 25 mg; take one tablet by mouth daily -FT Ear drops; apply five drops to both ears as needed -loperamide 2 mg; take one capsule by mouth with first loose stool, then once capsule with each subsequent loose stool (maximum 16 mg in 24 hours) R1's record lacked signed prescriber orders for the medications listed above. R1's prescriber orders dated January 18, 2024, included: -glipizide 10 mg; take one tablet by mouth once a day. -Reglan 10 mg; take one tablet by mouth three times a day for nausea and vomiting. R1's MAR dated December 2024, did not include glipizide or Reglan. On December 17, 2024, at 10:19 a.m., during a phone call with clinical nurse supervisor (CNS)-C, she stated the licensee used E-Scripts for most prescriber orders. CNS-C stated she called the pharmacy to request the missing prescriptions, but they were not able to provide them as they recently switched to this pharmacy, and the pharmacy did not receive copies of the previous E-Scripts. CNS-C stated she would provide updated orders to the surveyor later in the day. On December 17, 2024, at 11:18 a.m., CNS-C arrived at the facility and provided updated prescriber orders for R1. The updated prescriber orders included all R1's current medications; however, the orders were dated December 17, 2024, after the survey had started. CNS-C stated she sent an updated medication list to R1's provider to review and return since the pharmacy	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01820	Continued From page 44 was not able to provide E-scripts to the surveyor. The licensee's Medication Administration policy dated January 16, 2022, indicated all medications are prescribed, adjusted ad discontinued with physician orders. This includes over the counter medications, supplements, and herbals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01940 SS=D	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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01940	Continued From page 45 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (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 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: During the entrance conference on December 16, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment management services to their residents. R1 was admitted on January 22, 2024, with diagnoses that included diabetes. R1's service plan dated September 24, 2024, indicated R1 received assistance with bathing, walking, housekeeping, laundry, meals, and medication administration. The service plan did	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068		
(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
01940	Continued From page 46 not include blood sugar checks. R1's signed prescriber orders dated January 25, 2024, included: -test blood sugar one time a day as directed. R1's records lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. On December 17, 2024, at 11:25 a.m., clinical nurse supervisor (CNS)-C stated R1's record did not include an Individualized Treatment Management Plan. The licensee's Individualized Treatment and Therapy Management Plans policy dated January 8, 2024, indicated the licensee would develop and maintain an Individualized Treatment and Therapy Management Plan for each resident receiving treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
01940	Continued From page 47 days	01940			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, staff, and visitors of 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) 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 December 17, 2024, at 6:55 a.m., the surveyor observed one unsecured oxygen cylinder in the living room next to a recliner. On December 17, 2024, during the engineer's survey visit, the engineer observed R3's room with one unsecured oxygen cylinder on the floor near R3's window.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25861	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER GONDOLA GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 159TH COURT WEST ROSEMOUNT, MN 55068			
(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
02310	Continued From page 48 On December 17, 2024, at 11:56 a.m., licensed assisted living director (LALD)-A stated they kept a cylinder of oxygen in the living room for R3. LALD-A stated the cylinder of oxygen was unsecured. LALD-A further stated she was unaware of the unsecured oxygen cylinders in R3's room and would remind R3 to store his oxygen in secured holder. The licensee's Oxygen Use policy dated January 8, 2024, indicated oxygen tanks/cylinders should be stored in an upright position and secured to prevent them from falling over. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			

Type: Full
Date: 12/16/24
Time: 11:24:11
Report: 1004241219

Food and Beverage Establishment Inspection Report

Page 1

Location:

Gondola Group Inc
4307 159th Court West
Rosemount, MN55068
Dakota County, 19

Establishment Info:

ID #: 0038056
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524573619
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 >160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 31 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: 30 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- SANITIZER USE AND TEST KITS
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES

Type: Full
Date: 12/16/24
Time: 11:24:11
Report: 1004241219
Gondola Group Inc

Food and Beverage Establishment Inspection Report

Page 2

-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS,
NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*NO VIOLATIONS OBSERVED DURING TIME OF INSPECTION.

*REPORT WAS DISCUSSED WITH THE CO-OWNERS AND STAFF ON SITE, AS WELL AS WITH
THE NURSE EVALUATOR, KASSIE.

*FLOORS ARE FINISHED WOOD, WALLS ARE PAINTED DRYWALL, AND CEILING IS "POPCORN"
TEXTURE. COUNTERTOPS ARE LAMINATE AND CABINETS ARE PAINTED WOOD WITH HALLOW
BASE. ALL ARE 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.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK.
THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF
HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE
RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

**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 1004241219 of 12/16/24.

Certified Food Protection Manager SAMANTHA JO LASKA

Certification Number: FM53323 Expires: 10/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us