Electronically Delivered

November 8, 2022

Administrator
Gabby Care Homes, LLC
1512 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL34026015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 26, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division

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

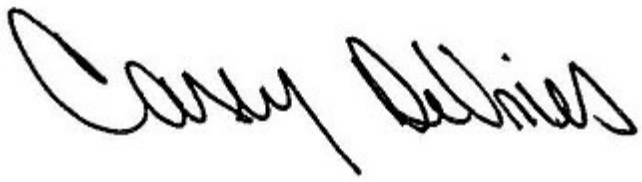
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34026	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC	1512 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34026015-0 On October 24, 2022, through October 26, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 residents, all of whom received services under the provider's Assisted Living license. On October 24, 2022, an immediate correction order was identified for SL34026015-0, tag identification 0820, and was issued to the licensee on October 26, 2022.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop an individual abuse prevention plan (IAPP) that included specific measures to be taken to minimize the risk of abuse for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 admitted to the licensee for services on February 25, 2019. R1's diagnosis included schizoaffective disorder (mental illness in which a person may experience a combination of symptoms of schizophrenia and mood disorder), altered mental status, and Bell's	0 630		

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0 630	Continued From page 2 palsy (condition that causes temporary weakness or paralysis of the muscles in the face). R1's Service Plan (Wavier) - Addendum to Contract signed March 3, 2022, indicated R1 received assistance with mobility, bathing, behavior management, falls prevention, housekeeping, dressing, grooming, toileting, meals, and medication administration. R1's Individual Abuse Prevention Plan completed September 7, 2022, indicated R1 was at risk to be abused by others. R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to the resident. On October 25, 2022, at 1:50 p.m., registered nurse (RN)-A stated it was an oversight that R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to the resident. The licensee's Vulnerable Adult Maltreatment -Prevention & Reporting dated August 1, 2021, indicated the licensee developed individualized vulnerable abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 3 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 4 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Arrangements with Other Facilities; - Names and Contact Information including residents' physicians; - Emergency Officials Contact Information including MN Office of Ombudsman for Long Term Care; and - Emergency Prep Testing Requirements. On October 25, 2022, at 10:10 a.m., registered nurse (RN)-A stated the licensee removed content in error when editing the emergency disaster preparedness plan. The licensee's Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated the licensee emergency preparedness plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire	0 790		

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0 790	Continued From page 5 Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 October 24, 2022, between 12:20 p.m. and 2:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed that the portable fire extinguisher in the basement of the 1510 building did not have a label or tag indicating when monthly inspections have been completed. During the facility tour interview, RN-A confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 790		

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0 790	Continued From page 6 (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 October 24, 2022, between 12:20 p.m. and 2:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1512 Building: 1. The door in the kitchen that led to the outside deck was labeled as an exit on the evacuation	0 800		

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0 800	Continued From page 7 maps posted in the facility. This exit leads to a landing enclosed by deck railings, obstructing the path for escape. 2. Burnt cigarette butts were observed on the wood ramp in the garage. 3. The closet door was out of the bottom track in resident room GH1. The closet knob was missing in resident room GH4. 4. An exposed screw was observed on the floor of the wood ramp in the garage. 5. The walk-in closet light was not working in resident room GH3. Three light bulbs were not working and one bulb was missing from the bathroom light fixture on the main floor. 6. The carpet was stained and soiled in the basement bedrooms and living room. 1510 Building: 1. A plastic sled was observed on the bottom of the window well for a bedroom egress window. The RN-A removed the sled during the tour and confirmed that this window well needs to be free of all obstructions that limit the egress window from being fully opened. 2. Burnt cigarette butts were observed on the wood deck at the back of the building. 3. One electrical outlet cover was cracked in resident room HH2. 4. The carpet was stained and soiled in basement bedroom HH4. During the facility tour interview, RN-A confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 8	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the	0 810		

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0 810	Continued From page 9	0 810		

required plans and training for fire safety and evacuation. This had the potential to directly affect all residents and staff.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 October 24, 2022, between 12:20 p.m. and 2:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed that the floor plans were not accurate that were included as part of the evacuation maps posted in the facility. During the facility tour interview, RN-A confirmed the findings.

On October 24, 2022, at approximately 3:00 p.m., RN-A and the licensed assisted living director (LALD)-C provided documents for review. Documents were reviewed by survey staff on October 24, 2022, between 3:00 p.m. and 3:30 p.m.

1. The fire safety and evacuation plans were not developed and maintained for the facility location. The fire policy dated 02/15/18 references smoke compartment doors, sprinklers, and magnetic holders which were not identified in the plans or observed during the facility tour. The emergency operations plan for internal fires dated January 2022 references pull fire alarms which were not identified or observed during the facility tour.
2. The fire safety and evacuation plans did not include the identification of unique or unusual

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0 810	Continued From page 10 resident needs for movement or evacuation. 3. Employee training on fire safety and evacuation was completed upon hire and then annually using an online educational program. The licensee failed to provide documentation supporting employee training frequency on the facility's fire safety and evacuation plans. This training is required upon hire and at least twice per year thereafter. 4. Documentation supporting annual training for residents on the proper actions to take in the event of a fire was requested but not provided. On October 24, 2022, at approximately 3:45 p.m., during an interview, RN-A and the LALD-C confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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(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
0 820	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including, the minimum size egress window openings for resident bedrooms, did not create a distinct hazard to residents and staff. This affected four occupied resident bedrooms. 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 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). On October 24, 2022, between 12:20 p.m. and 1:50 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed that resident sleeping rooms GH1 and GH2 in the 1512 building and H1 and H2 in the 1510 building did not have windows that met the minimum size requirements for egress escape. Residents occupied these four rooms. The windows did not meet the minimum required opening for existing sleeping rooms of 20 inches in height or width. At least one window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet) required for assisted living facilities. During the tour, RN-A confirmed the findings. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34026	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for three of three residents (R1, R2, R3).	0 950		

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	34026	A. BUILDING: _____ B. WING _____	10/26/2022

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0 950	Continued From page 13	0 950		

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1
R1 admitted to the licensee for services on February 25, 2019.

R1's Resident Contract for Assisted Living was signed August 21, 2021.

R2
R2 admitted to the licensee for services on December 13, 2019.

R2's Resident Contract for Assisted Living was signed August 1, 2021.

R3
R3 admitted to the licensee for services on April 27, 2022.

R3's Resident Contract for Assisted Living was signed April 27, 2022.

R1, R2, and R3's Resident Contract for Assisted Living lacked the verbatim "right to designate a representative for certain purposes" notice.

On October 26, 2022, at 11:30a.m., licensed assisted living director (LALD)-C stated the licensee lacked understanding of the

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	34026	A. BUILDING: _____ B. WING _____	10/26/2022

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GABBY CARE HOMES LLC	1512 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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
0 950	Continued From page 14 requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

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01730	Continued From page 15 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management plan with the required content for three of three residents (R1, R2, 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) 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 On October 25, 2022, at approximately 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-B attempt to administer R1's oral medication. R1's Service Plan (Wavier) - Addendum to Contract signed March 3, 2022, indicated R1	01730		

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01730	Continued From page 16	01730		

received assistance with mobility, bathing, behavior management, falls prevention, housekeeping, dressing, grooming, toileting, meals, and medication administration.

R1's provider orders dated July 30, 2022, indicated R1 received aspirin 81 milligrams (mg), folic acid 1 mg, lisinopril 10 mg, venlafaxine 150 mg, Vitamin D3 25 micrograms (mcg), olanzapine 5 mg, mirtazapine 15 mg, risperidone 2mg, lamotrigine 300 mg, gabapentin 300 mg, loratadine 10 mg as needed (PRN), loperamide 2 mg PRN, and acetaminophen 650mg PRN.

R1's Individualized Medication Management Plan completed on September 7, 2022, included medication management tasks that may be delegated to the unlicensed personnel as topical and lacked information pertaining R1's oral medications. The Individual Medication Management Plan lacked current medication management delegated to the ULPs.

R2
On October 25, 2022, at approximately 8:04 a.m., the surveyor observed ULP-D administer oral medication to R2.

R2's Service Plan (Waiver)- Addendum to Contract signed August 1, 2021, indicated R2 received assistance with activity assistance, bathing, behavior management, dressing, grooming, housekeeping, meals, medication administration, and shopping assistance.

R2's provider orders dated August 3, 2022, indicated R2 received pantoprazole 40 mg, Vitamin D3 25mcg, Flonase nasal spray 50 mcg, risperidone 1 mg, clonidine 0.2 mg, divalproex sodium extended release (ER) 1250 mg,

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01730	Continued From page 17 olanzapine 5 mg, hydroxyzine 10 mg, and mirtazapine 15 mg. R2's Individualized Medication Management Plan completed on October 19, 2022, included medication management tasks that may be delegated to the unlicensed personnel as inhaler and lacked information pertaining R2's oral medications. The Individual Medication Management Plan lacked current medication management tasks delegated to the ULPs. R3 On October 28, 2022, at approximately 8:40 a.m., the surveyor observed ULP-B administer R3's oral medication. R3's Service Plan (Waiver) - Addendum to Contract signed May 10, 2022, indicated R3 received assistance with activity assistance, bathing, behavior management, grooming, housekeeping, meals, medication administration, and shopping assistance. R3's Med Admin Summary -Actual- Month dated October 2022, indicated R3 received aripiprazole 20 mg, and Nizoral 2 percent (%) topical shampoo. R3's Individualized Medication Management Plan competed August 1, 2022, included medication management tasks that may be delegated to the unlicensed personnel as topical and lacked information pertaining R3's oral medications. The Individual Medication Management Plan lacked current medication management delegated to the ULPs. On October 25, 2022, at 11:55 a.m., registered nurse (RN)-A stated they believed another RN did	01730		

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01730	Continued From page 18 not understand what was being asked on the medication assessment and all resident's individualized medication management plans would lack information pertaining to oral medication to be provided by the ULP. The licensee's Medication Management Individualized Plan dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident assessment that must contain identification of medication management task that may be delegated to the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01830		

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01830	Continued From page 19 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 admitted to the licensee for services on February 25, 2019. R1's diagnosis included schizoaffective disorder (mental illness in which a person may experience a combination of symptoms of schizophrenia and mood disorder), altered mental status, and Bell's palsy (condition that causes temporary weakness or paralysis of the muscles in the face). R1's Service Plan (Wavier) - Addendum to Contract signed March 3, 2022, indicated R1 received assistance with mobility, bathing, behavior management, falls prevention, housekeeping, dressing, grooming, toileting, meals, and medication administration. R1's most recent provider orders for 25 medications were signed on July 30, 2021. On October 25, 2022, at 11:57 a.m., registered nurse (RN)-A stated the licensee was attempting to establish a new primary provider for R1. In addition, RN-A stated the licensee was aware prescription orders needed to be renewed yearly however, R1's new primary provider would not provide a medication order for the licensee until R1 was seen in clinic. The licensee's Medication & Treatment Orders - Renewal dated August 1, 2021, indicated medication and treatment orders would be	01830		

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01830	Continued From page 20 renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01850 SS=E	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written or electronic prescription placed into the resident record for two of four residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 admitted to the licensee for service on April 27, 2022.	01850		

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01850	Continued From page 21 R3's Service Plan (Waiver) - Addendum to Contract signed May 10, 2022, indicated R3 received assistance with activity assistance, bathing, behavior management, grooming, housekeeping, meals, medication administration, and shopping assistance. R3's Med Amin Summary - Actual - Month dated October 2022, indicated R3 received aripiprazole 20 milligram (mg) tab daily, Nizoral 2 percent (%) topical shampoo three times per week. R3's medical record lacked a provider order for Nizoral 2 percent (%) topical shampoo three times per week. On October 26, 2022, at 11:43 a.m., registered nurse (RN)-A stated R3's Nizoral 2 percent (%) topical shampoo prescription was sent to a different pharmacy not used by licensee, and they did not have the provider order in R3's medical record. R4 R4 admitted to the licensee for services on August 26, 2019. R4's Service Plan (Waiver) - Addendum to Contract signed August 1, 2021, indicated R4 received assistance with activity assistance, bathing, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, and shopping assistance. R4's Med Admin Summary -Actual Month dated October 2022, included Vitamin B12 1,000 units (U) daily, Vitamin D 2000 U daily, divalproex 1000 mg daily, hydroxyzine pamoate 25 mg daily, mirtazapine 7.5 mg daily, quetiapine 300 mg	01850		

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01850	Continued From page 22 daily, risperidone 3 mg daily, and melatonin 5 mg as needed (PRN). R4's medical record lacked a provider order for Vitamin B12 1,000 U daily, and Vitamin D 2000 U daily. On October 26, 2022, at 11:43 a.m., RN-A stated R4's provider orders for Vitamin B12 1,000 U daily, and Vitamin D 2000 U daily were not located in the R4's medical record because R4's mother had not provided the medication prescription to the licensee. The licensee's Medication & Treatment Orders - Renewal dated August 1, 2021, indicated residents who received medication management by the licensee would have current prescribed medication or treatment orders on record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01850		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely for one of three residents (R3).	01880		

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01880	Continued From page 23 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: R3 admitted to the licensee for services on April 27, 2022. R3's Service Plan (Waiver) - Addendum to Contract signed May 10, 2022, indicated R3 received assistance with activity assistance, bathing, behavior management, grooming, housekeeping, meals, medication administration, and shopping assistance. R3's Individualized Medication Management Plan competed August 1, 2022, indicated R3's medications would be stored in a key locked cabinet and only the scheduled staff would have access to the medication. On October 26, 2022, at 9:37 a.m., the surveyor observed R3's ketoconazole 2 percent (%) shampoo on the sink of the lower-level bathroom. On October 26, 2022, at approximately 11:25 a.m., licensed assisted living director (LALD)-C stated employees were trained to lock all medications in medication cabinet. The surveyor then observed LALD-C remove the medication from the bathroom sink. LALD-C stated the licensee would need to provide training to	01880		

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01880	Continued From page 24 employees on medication security. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be kept securely locked and stored per manufacturer's directions and only authorized staff will have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health

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

Type: Full
Date: *10/26/22*
Time: 12:00:00
Report: 8087221238

Food and Beverage Establishment Inspection Report

Location:
Gabby Care Homes Llc
1512 Pennsylvania Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038555
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632048841
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -3 Degrees Fahrenheit - Location: FREEZER (1512)
Violation Issued: No

Process/Item: Ambient Air
Temperature: -6 Degrees Fahrenheit - Location: FREEZER (1510)
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1512)
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1512)
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1512)
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1512)
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1512)
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1510)
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1510)
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1510)
Violation Issued: No

Process/Item: Cold Holding: CREAM CHEESE
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1510)
Violation Issued: No

Process/Item: Cold Holding: HOT DOGS
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR (1510)
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

FLOORS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING IS TEXTURED. 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.

KENMORE (1512) AND WHIRLPOOL (1510) BRAND DISHWASHERS ARE RESIDENTIAL BUT HAVE SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 (1512) AND 121 (1510) DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN ON THE LEFT (1512) AND RIGHT (1510), IN 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINKS.

RESIDENTIAL KENMORE (1512) AND WHIRLPOOL (1510) REFRIGERATORS OBSERVED.

RESIDENTIAL WHIRLPOOL (1512) AND GE (1510) STOVE/RANGE OBSERVED.

INSPECTION REPORT EMAILED TO ASHLEY CREWS (RN, NURSING EVALUATOR).

Type: Full
Date: *10/26/22*
Time: 12:00:00
Report: 8087221238
Gabby Care Homes Llc

Food and Beverage Establishment Inspection Report

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 8087221238 of 10/26/22.

Certified Food Protection Manager: JOY M. MORABU

Certification Number: FM110188 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JOY M. MORABU
MANAGER

Signed: _____

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