



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 14, 2025

Licensee

Great Home MN Aviary LLC

8811 Aviary Path

Inver Grove Heights, MN 55077

RE: Project Number(s) SL33375016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 10, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GREAT HOME MN AVIARY		STREET ADDRESS, CITY, STATE, ZIP CODE 8811 AVIARY PATH INVER GROVE HEIGHTS, MN 55077			
(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: SL33375016-0 On December 9, 2024, through December 11, 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. 2310: An immediate order was issued on December 9, 2024, at a level 2/Widespread (F). The licensee took action to minigate risk, but remains at level F.	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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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	0 680			

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0 680	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan dated April 2, 2024, was reviewed and lacked the following: - Emergency prep training program to include initial training in EP for all staff and to include at least annual training. - conduct exercises 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; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On December 10, 2024, at 10:35 a.m., chief financial officer/maintenance (CFO/M)-C confirmed the licensee was lacking annual EP training and testing of the EP program. CFO/M-C stated he was unaware staff had not completed annual training and was not aware of the requirement for testing of the EP program. The licensee's Emergency Preparedness policy dated February 1, 2023, indicated the licensee will have an identified plan in place to assure the	0 680			

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0 680	Continued From page 5 safety and well-being of residents and staff, referencing Centers for Medicare and Medicaid (CMS) State Operations Manual Appendix Z. MN Rules 4659.0100. No additional 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 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 provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 790			

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0 790	Continued From page 6 or has potential to affect a large portion or all of the residents). The findings include: On a facility tour with chief financial officer and maintenance (CFO/M)-E on December 11, 2024, from 10:30 a.m. to 1:00 p.m., The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. On December 11, 2024, at 12:00 p.m., CFO/M-E, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810			

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0 810	Continued From page 7 (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 with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2024, from approximately 10:30 a.m. to 1:00 p.m.; surveyor observed the posted evacuation plans lacked identification of resident rooms and resident rooms 1, 2, 5, and 6 were not labeled at all.	0 810			

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0 810	Continued From page 8 Fire evacuation diagrams did not include the identification of the path of egress Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On December 12, 2024, chief financial officer, and maintenance (CFO/M)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated, 2022, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. RESIDENT ACTIONS: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar	0 810			

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0 810	Continued From page 9 emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 12, 2024, at 12:30 p.m., CFO/M-E stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CFO/M-E lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as stated in the policy. CFO/M-E has been using a third-party vendor to complete all training requirements which are not specific to the facility. No other training documentation was provided. On December 12, 2024, at 12:30 p.m., CFO/M-E stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills	0 810			

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0 810	Continued From page 10 for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills Log", from a third-party vendor dated 2022, indicated evacuation drills were conducted on February 30, 2024, June 30, 2024, August 30, 2024, and November 30, 2024. Documentation was only dated with names of staff, no scenario provided, no shift or times were provided. On December 12, 2024, at 12:30 p.m., CFO/M-E stated there were no additional documented drills for the facility. Education was given that more information was needed, in accordance with facility policy and state statue. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 950 SS=F	144G.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	0 950			

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0 950	Continued From page 11 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 ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for one of one resident (R3). 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 the residents). The findings include: R3's Resident Service Agreement dated July 1, 2024, lacked the required notice to designate a representative. R3's record lacked evidence in writing of providing on a document separate from the	0 950			

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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
0 950	Continued From page 12 contact verbatim notice of "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." On December 10, 2024, at 12:40 p.m., chief financial officer/maintenance (CFO/M)-C stated R3's record did not have the required language to designate a representative and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
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;	01500			

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01500	Continued From page 13 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (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	01500			

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01500	Continued From page 14 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F). 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-F began providing assisted living services for the licensee on October 16, 2021. On December 10, 2024, at 8:10 a.m., the surveyor observed ULP-F administer morning medication to R4. ULP-F's employee training records lacked evidence ULP-F had successfully completed annual training as required in the following area: - reporting of maltreatment of vulnerable adults under section 626.557. - assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights.	01500			

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01500	Continued From page 15 - infection control techniques. - facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 10, 2024, at 10:35 a.m., chief financial officer/maintenance (CFO/M)-C confirmed ULP-F was lacking annual training and stated he was unaware that annual training was not completed. The licensee's Staff Orientation and Education policy dated February 1, 2023, indicated all staff providing assisted living services will complete at least eight hours of education for every twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

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01620	Continued From page 16 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of one resident (R3) as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3's was admitted to the facility on August 22, 2022, with a diagnosis of schizophrenia. R3's service plan dated February 1, 2024, indicated the resident received assistance with activities of daily living (ADLs) and medication	01620			

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01620	Continued From page 17 management. On December 10, 2024, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-F assist R3 with toileting, showering, and dressing. R3's record indicated the assessments by the registered nurse (RN) had completion dates as follows: - October 18, 2023. - April 13, 2024 (178 days after the previous assessment) In addition, R3's record failed to show evidence an assessment was completed after April 13, 2024. On December 10, 2024, at 11:44 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she could not find an assessment for R3 after April 13, 2024. RN-C stated she had not been completely trained in using the software so she entered a progress note, rather than completing an assessment. The licensee's Assessment and Reassessment policy dated February 1, 2023, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 18 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 ensure the medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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 the residents). The findings include: On December 10, 2024, at 1:00 p.m., the surveyor reviewed the medication refrigerator with registered nurse (RN)-B. The refrigerator contained a box of Humira insulin. No evidence of a temperature log was found. RN-B stated she was unaware daily temperature checks were needed for the medication refrigerator, so they were not doing that. Unlicensed personnel (ULP)-F stated they check temperatures of the kitchen refrigerators daily and showed the surveyor the temperature logs, but was unaware the medication refrigerator needed daily temperature checks.	01880			

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01880	Continued From page 19 The manufacturer's instructions for Humira insulin pens dated June 2016, indicated to store Humira in the refrigerator between 36-46 degrees. Do not freeze Humira. The licensee's Storage/Control of Medications policy dated February 1, 2023, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or are separated from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910			

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01910	Continued From page 20 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's prescription number, as applicable, and to whom the medications were given for one of one discharged 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 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: R1 started receiving services for assistance with activities of daily living and medication management on November 6, 2020. R1's record contained a list of scheduled medications and the current amount at discharge with a signature of staff. The form did not include the prescription numbers as required. R1 was discharged from the facility on December 17, 2023. R1's discharge note dated December 17, 2023, at 11:30 p.m., indicated the resident had expired. On December 9, 2024, at 1:00 p.m., licensed	01910			

Minnesota Department of Health

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01910	Continued From page 21 assisted living director/registered nurse (LALD/RN)-A stated she was unaware of the requirement to include the prescription number on the form. The licensee's Disposition and Disposal of Medications policy dated February 1, 2023, indicated upon disposition, [licensee name] will document the name, strength and prescription number of medication, quantity, and date of disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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 ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents with siderails (R3, R4). This practice resulted in a level two violation (a violation that did not harm a client/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	02310			

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02310	Continued From page 22 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: R3 R3 began receiving services from the licensee on August 22, 2022, under the facility's assisted living license with a diagnosis of schizophrenia. R3 received a hospital bed with siderails from the facility in December 2022. R3's Service Plan dated February 1, 2024, indicated she received services to include medication administration, and activities of daily living (ADL's). On December 9, 2024, at 11:00 a.m. during the facility tour with licensed assisted living director/registered nurse (LALD/RN-A) and registered nurse (RN-B), the surveyor observed R3's room contained a hospital bed with top and bottom siderails in the up position on both sides of the bed (four side rails). On December 9, 2024, at 2:30 p.m., RN-B was observed measuring R3's hospital bed and R3 stated she did not like the siderails and wanted them removed. RN-B removed the siderails. R3's record included a siderail assessment dated January 17, 2023. The document lacked evidence of siderail measurements or a discussion with R3 or a designated representative of risk vs benefit of side rail use. In addition, there were no further assessments noted in R3's record to indicate the siderails were reevaluated.	02310			

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02310	Continued From page 23 R4 R4 began receiving services from the licensee on January 30, 2024, with a diagnosis of multiple sclerosis and was bedridden. R4 was admitted to the facility with a hospital bed including a side rail. R4's service plan dated February 17, 2024, indicated she received services to include medication administration, and assistance with ADLs. R4's record included a siderail assessment dated April 13, 2024. The document lacked evidence of siderail measurements or a discussion with R4 or designated representative of risk vs benefit of side rail use. On December 9, 2024, at 11:00 a.m. during the facility tour with LALD/RN-A and RN-B, the surveyor observed R4's room contained a hospital bed with bilateral upper siderails in the up position. R4 was not able to be interviewed. On December 9, 2024, at 2:00 p.m., LALD/RN-A stated they are aware of the procedure for siderail assessment measurements and had directed the staff to get measurements, but could not see them in the resident record. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also	02310			

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02310	Continued From page 24 identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310			

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02310	Continued From page 25 interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side rails policy dated August 1, 2021, indicated that when side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rails and the risks regarding the use of the side rail. The staff will determine if the side rail is considered to be safe. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 10, 2024. the licensee detailed actions taken to mitigate the risk of non-compliance. The scope and level remains at F.	02310			

Type: Full
Date: 12/10/24
Time: 19:34:13
Report: 1036241288

Food and Beverage Establishment Inspection Report

Page 1

Location:

Great Home MN Aviary Assisted
8811 Aviary Path
Inver Grove Heights, MN55075
Dakota County, 19

Establishment Info:

ID #: 0034018
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Great Home Minnesota LLC

Phone #: 6519832005

ID #: 48360

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG SENT ALONG WITH REPORT.

Comply By: 12/18/24

3-500C Microbial Control: date marking

3-501.17A

**** Priority 2 ****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

OBSERVED AN OPENED BAG OF SHREDDED CHEESE IN THE ARCTIC AIR COOLER AND A CONTAINER OF BEANS IN THE FRIGIDAIE COOLER WITH NO DATE LABEL. ISSUE CORRECTED ON SITE.

Comply By: 12/10/24

4-300 Equipment Numbers and Capacities

4-302.12B

**** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETER DEVICE AS DESCRIBED ABOVE ON SITE. PROVIDE AND MAINTAIN.

Comply By: 01/08/25

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4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE ON SITE FOR MEASURING THE UST IN THE DISH MACHINE. MDH LEFT A FEW THERMOLABEL TEST STRIPS FOR ESTABLISHMENT. PROVIDE AND MAINTAIN.

Comply By: 01/08/25

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CHLORINE SANITIZER TEST KIT ON SITE. PROVIDE AND MAINTAIN.

Comply By: 01/08/25

4-500 Equipment Maintenance and Operation

4-501.116 ** Priority 2 **

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

CHLORINE SANITIZER SPRAY BOTTLE WAS TESTED AT 200PPM. ENSURE SANITIZER CONCENTRATION IS MAINTAINED BETWEEN 50-100PPM.

Comply By: 01/08/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM AT ESTABLISHMENT. INFORMATION ON FOOD SAFETY CLASS AND OBTAINING A CFPM WAS SENT TO ESTABLISHMENT ALONG WITH REPORT.

Comply By: 01/08/25

Surface and Equipment Sanitizers

Chlorine: = 200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: Yes

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/BUTTER
Temperature: 40 Degrees Fahrenheit - Location: ARCTIC AIR DD COOLER
Violation Issued: No

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Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: ARCTIC AIR DD COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: FRIGIDAIRE COOLER
Violation Issued: No

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

Process/Item: Ambient Temp
Temperature: -1 Degrees Fahrenheit - Location: ARCTIC AIR DD FREEZER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	5	1

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TRACEY FEARON. INSPECTION CONDUCTED IN PRESENCE OF JOVELINE OBAY, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

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

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

I acknowledge receipt of the inspection report number 1036241288 of 12/10/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

JOVELINE OBAY
PERSON IN CHARGE

Signed: _____

Jeff Johanson