



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 31, 2024

Licensee

EvyGabs Healthcare Systems LLC

20604 Enfield Avenue North

Forest Lake, MN 55025

RE: Project Number(s) SL36395016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 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,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Evygabs Healthcare Systems LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36395016-0 On November 18, 2024, through November 20, 2024, 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 5 residents, all of whom were receiving services under the provider's provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 480	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 480	Continued From page 2 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 November 20, 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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 3	0 680			
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 maintain a written emergency preparedness (EP) plan with allrequired content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP, last reviewed August 1, 2024, lacked evidence of the following required content: -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On November 19, 2024, at 10:30 a.m., administrator and owner (A/O)-A stated an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise had not been done, and he was not aware of the requirement. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy, dated August 1, 2024, indicated the licensee would conduct at minimum, an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 730	Continued From page 5	0 730			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 730	Continued From page 6 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident record included documentation of an initial service plan for one of two residents (R2). 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: R2 was admitted on October 21, 2021, with diagnoses to include schizoaffective disorder (a condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression). On November 19, 2024, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2's unsigned service plan, dated November 6,	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 730	Continued From page 7 2024, indicated R2 received services to include medication administration, housekeeping, laundry, and behavior management. R2's record lacked documentation of an initial signed service plan. On November 19, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated it was her process to provide the resident with the service plan on admission and have them sign an attestation of receipt, but she did not keep a copy of the service plan for the resident record. LALD/RN-B further stated she was unable to find R2's attestation and she would change her process. On November 19, 2024, at 1:30 p.m., R2 stated she received an initial service plan when she admitted to the licensee's facility. The licensee's 6.08 Service Plan policy, dated June 1, 2024, indicated service plans and any revisions or updates would be entered into the resident's record. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 730			
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,	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 790	Continued From page 8 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 deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 November 19, 2024, at approximately 12:30 p.m., survey staff toured the facility with administrator and owner (A/O)-A. The portable fire extinguishers throughout the facility where not installed on their required wall mount brackets. Survey staff explained to A/O-A that the portable fire extinguishers must be mounted to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. A/O-A stated they understood the requirements and would mount the fire extinguishers on the provided brackets. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Evygabs Healthcare Systems LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, at approximately 12:30 p.m., survey staff toured the facility with administrator and owner (A/O)-A. The following was observed:	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
0 800	Continued From page 10 GENERAL MAINTENANCE: The ceiling in the main living room, and the lower-level office, was heavily stained. A/O-A stated they had a leak above the ceiling in the past that was repaired, but the ceiling had not been repaired. The laundry room sink faucet was leaking. A/O-A had a bucket in the utility sink to catch the slow drip and was aware that the faucet needed repair. The light fixture in the upper-level hallway and the walk-in closet for bedroom 2 did not work. The window screen in bedroom 4 was partially ripped. Damaged or missing screens in windows can serve as access points to pests and rodents. The handle on the window in bedroom 4 was broken. A/O-A stated they were unaware of the broken handle and would get it looked at. The sidewalk leading from the driveway to the main entrance was damaged and sinking. Walking surfaces used by residents and visitors must be maintained and properly installed, secure, and not create possible tripping hazards. The hardwired smoke alarm in bedroom 4 gave a faint alarm. Smoke detectors are required to maintain a minimum audible decibel level in accordance with current Minnesota Fire Code. On November 19, 2024, at approximately 1:30 p.m., A/O-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810 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. (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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 12 safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, administrator and owner (A/O)-A 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, failed to include the following: 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 FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Evygabs Healthcare Systems LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 13 to follow in case of relocation. On November 19, 2024, at approximately 1:30 p.m., A/O-A 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. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
01060	Continued From page 14 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident or the resident's legal representative for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's unsigned service plan, dated November 6,	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
01060	Continued From page 15 2024, indicated R2 received services to include medication administration, housekeeping, laundry, and behavior management. R2's resident note, dated June 29, 2024, at 10:56 a.m., indicated R2 was taken to the hospital. R2's resident note, dated July 1, 2024, at 3:16 p.m., indicated R2 returned from the hospital at 2:10 p.m. R2's record lacked documentation an emergency relocation notification was provided to the resident or the resident's representative. On November 19, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated she had not provided any emergency relocation notification to residents or their representative and she was not aware of the requirement. The licensee's 1.23 Emergency Relocation policy, dated June 1, 2024, indicated a written notice with the required content would be provided to the resident and legal representative in the case of an emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
01470	Continued From page 16 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) health impacts related to untreated	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
01470	Continued From page 17 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-C). 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-C was hired September 6, 2023, to provide direct care services for the licensee's residents. On November 19, 2024, during continuous observation from 7:20 a.m. to 8: 30 a.m., ULP-C assisted the licensee's residents with medication administration and morning cares.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(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
01470	Continued From page 18 ULP-C's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the appropriate Assisted Living statutes 144G and rules; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of Assisted Living services the employee will provide and provider's scope of license. On November 20, 2024, via email at 1:47 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated she had missed assigning the required education to ULP-C on hire, LALD/RN-B further stated, "I have gone ahead and assigned her the course, and she should complete it today." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated June 1, 2024, indicated orientation would include all the required topics and documented in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 19 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training, in the required time frame for one of two employees (unlicensed personnel (ULP)-C). 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).	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 20 The findings include: ULP-C was hired September 6, 2023, to provide direct care services for the licensee's residents. On November 19, 2024, during continuous observation from 7:20 a.m. to 8: 30 a.m., ULP-C assisted the licensee's residents with medication administration and morning cares. ULP-C's employee record lacked documentation they had completed the required 8 hours of initial dementia care training within 160 hours of working. On November 19, 2024, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated ULP-C had not completed the above required training. LALD/RN-B further stated she thought she needed to assign eight courses related to dementia care and was not aware there was an hour requirement. The licensee's 5.03 Dementia Training policy, dated June 1, 2024, indicated direct care staff would complete eight hours of initial dementia care training within160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 21 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for one of two residents (R2). 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 22 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted October 21, 2021, and received services to include medication management. On November 19, 2024, at 7:35 a.m., unlicensed personnel (ULP)-C was observed assisting R2 with medication administration. R2's record included an initial comprehensive nursing assessment, dated October 21, 2021, and a subsequent RN reassessment, dated November 11, 2021, (7 days past the 14-day due date). On November 19, 2024, at 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated R2's 14-day assessment was completed late, and she was unsure why. The licensee's 6.01 Assessments Reviews & Monitoring policy, dated June 1, 2024, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EYVGABS HEALTHCARE SYSTEMS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 23 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for two of two residents (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, 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).	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EYVGABS HEALTHCARE SYSTEMS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 24 The findings include: R2 R2 had diagnoses to include schizoaffective disorder (a condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression). On November 19, 2024, at 7:35 a.m., the surveyor observed ULP-C assist R2 with medication administration. R2's unsigned service plan, dated November 6, 2024, indicated R2 received services to include assistance with medication administration, housekeeping, laundry and behavior management. R3 R3 was admitted on November 27, 2023, with diagnoses to include schizophrenia (mental health condition that affects how people think, feel, and behave). R3's unsigned service plan, dated November 6, 2024, indicated R3 received services to include assistance with medication administration, bathing, and behavior management. On November 19, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated she had not been getting current service plans signed by the resident or resident representative. LALD/RN-B further stated she would change her process. The licensee's 6.08 Service Plan policy, dated June 1, 2024, indicated the service plan and any	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER EVYGABS HEALTHCARE SYSTEMS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 25 revisions would include a signature or other authentication by the licensee and the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: 11/20/24
Time: 15:15:00
Report: 1025241243

Food and Beverage Establishment Inspection Report

Page 1

Location:

Evygabs Healthcare Systems Llc
20604 Enfield Avenue North
Forest Lake, MN55025
Washington County, 82

Establishment Info:

ID #: 0037958
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514928643
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.

The following orders previously issued on 11/19/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

Staff reported underway to retake exam to submit for CFPM certificate; reviewed website and process during inspection

Woodbury location within 30 miles

Issued on: 11/19/24

Comply By: 11/19/24

No NEW orders were issued during this inspection.

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

Received confirmation batteries were replaced in TMD

Outside refrigerator reported to be moved indoors after testing overnight water temperature to help with maintaining cold TCS foods at or below 41 deg F.

Type: Follow-Up
Date: 11/20/24
Time: 15:15:00
Report: 1025241243
Evygabs Healthcare Systems Llc

Food and Beverage Establishment Inspection Report

Page 2

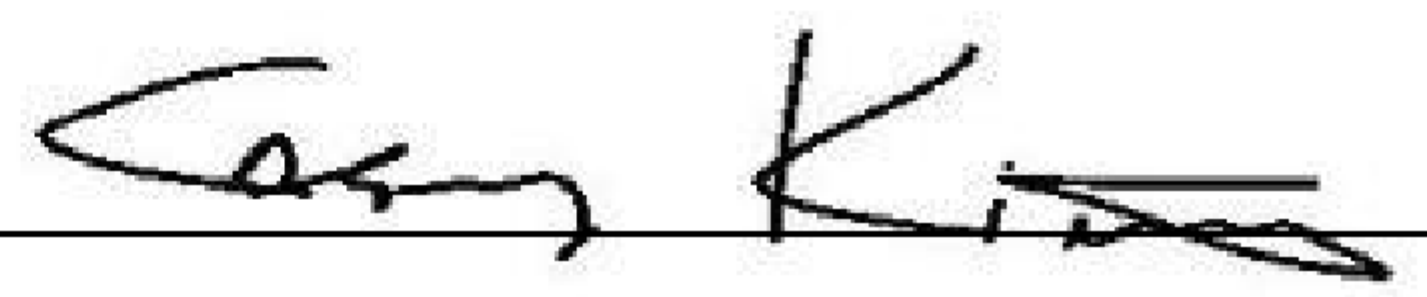
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241243 of 11/20/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____
Establishment Representative

Signed:  _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 11/19/24
Time: 12:00:00
Report: 1025241231

Food and Beverage Establishment Inspection Report

Page 1

Location:

Evygabs Healthcare Systems Llc
20604 Enfield Avenue North
Forest Lake, MN55025
Washington County, 82

Establishment Info:

ID #: 0037958
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514928643
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.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS foods in kitchen refrigerator at 42 deg, garage at 44 deg. Kitchen fridge turned down, garage fridge open for delivery, monitor temperatures in cooler and remove TCS foods if they do not stay under 41 deg F

Comply By: 11/19/24

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.

Provide a new battery or a replacement for the red food thermometer

Comply By: 11/20/24

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.

Provide a chlorine test kit

Comply By: 11/22/24

Type: Full
Date: 11/19/24
Time: 12:00:00
Report: 1025241231
Evygabs Healthcare Systems Llc

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
Staff reported underway to retake exam to submit for CFPM certificate; reviewed website and process during inspection
Woodbury location within 30 miles
Comply By: 11/19/24

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: Basin
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Yogurt
Temperature: 44 Degrees Fahrenheit - Location: Garage refrigerator
Violation Issued: Yes

Process/Item: Roast beef
Temperature: 42 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	2	1
Dishwasher not in operation during inspection, facility using a basin with 50 PPM bleach water for sanitizing. Discussed NSF 184 requirement for dishwashers, can send product info to email for verification before purchase to confirm a new unit meets requirements Reported leak repaired under kitchen sink on previous Sunday. The MDF underneath is still damp, recommend opening cabinets and getting a fan to dry the area Discussed appliances and same-day service of TCS foods – for pizza, etc if it's not a personal item, discontinue cooling/freezing these items if cooked Monitor temperatures in the garage refrigerator, if it doesn't maintain temperature, remove TCS foods or move the refrigerator inside the house Do not use the wood cutting board for food contact, recommend plastic boards which fit in the sanitizing bin and the dishwasher				

Type: Full
Date: 11/19/24
Time: 12:00:00
Report: 1025241231
Evygabs Healthcare Systems Llc

Food and Beverage Establishment Inspection Report

Page 3

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

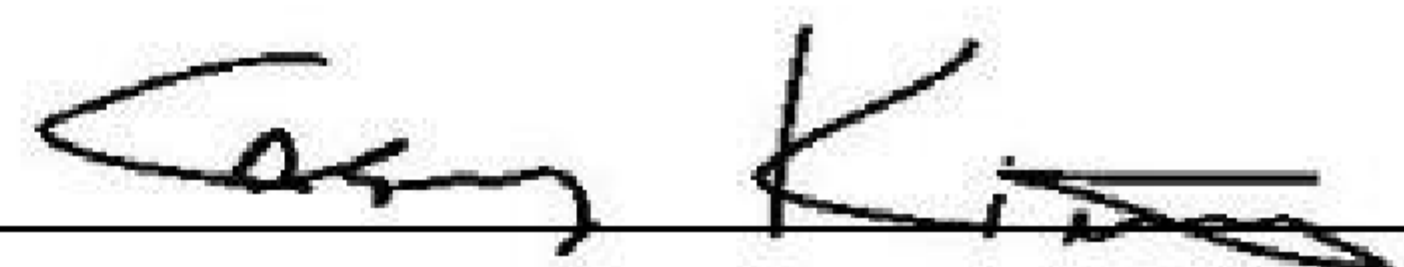
I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241231 of 11/19/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Establishment Representative

Signed:  _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241231		Food Establishment Inspection Report					
	Minnesota Department of Health Division of Environmental Health, FPLS P.O. Box 64975 St. Paul, MN 55164-0975		No. of RF/PHI Categories Out		2	Date 11/19/24	
			No. of Repeat RF/PHI Categories Out		0		
			Legal Authority MN Rules Chapter 4626				
Evvgabs Healthcare Systems Llc		Address 20604 Enfield Avenue North		City/State Forest Lake, MN		Zip Code 55025	Telephone 6514928643
License/Permit # 0037958		Permit Holder		Purpose of Inspection Full		Est Type Risk Category	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS							
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item							
Mark "X" in appropriate box for COS and/or R							
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation							
Compliance Status				COS		R	
Supervision							
1	IN	OUT	PIC knowledgeable; duties & oversight				
2	IN	OUT	N/A	Certified food protection manager, duties			
Employee Health							
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting				
4	IN	OUT	Proper use of reporting, restriction & exclusion				
5	IN	OUT	Procedures for responding to vomiting & diarrheal events				
Good Hygienic Practices							
6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use			
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands							
8	IN	OUT	N/O	Hands clean & properly washed			
9	IN	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	OUT		Adequate handwashing sinks supplied/accessible			
Approved Source							
11	IN	OUT		Food obtained from approved source			
12	IN	OUT	N/A	N/O	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated			
14	IN	OUT	N/A	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	OUT	N/A	N/O	Food separated and protected		
16	IN	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	IN	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		
GOOD RETAIL PRACTICES							
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.							
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation							
				COS		R	
Safe Food and Water							
30	IN	OUT	N/A	Pasteurized eggs used where required			
31				Water & ice obtained from an approved source			
32	IN	OUT	N/A	Variance obtained for specialized processing methods			
Food Temperature Control							
33				Proper cooling methods used; adequate equipment for temperature control			
34	IN	OUT	N/A	N/O	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	N/O	Approved thawing methods used		
36	X			Thermometers provided & accurate			
Food Identification							
37				Food properly labeled; original container			
Prevention of Food Contamination							
38				Insects, rodents, & animals not present			
39				Contamination prevented during food prep, storage & display			
40				Personal cleanliness			
41				Wiping cloths: properly used & stored			
42				Washing fruits & vegetables			
Proper Use of Utensils							
43				In-use utensils: properly stored			
44				Utensils, equipment & linens: properly stored, dried, & handled			
45				Single-use/single service articles: properly stored & used			
46				Gloves used properly			
Utensil Equipment and Vending							
47				Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48	X			Warewashing facilities: installed, maintained, & used; test strips			
49				Non-food contact surfaces clean			
Physical Facilities							
50				Hot & cold water available; adequate pressure			
51				Plumbing installed; proper backflow devices			
52				Sewage & waste water properly disposed			
53				Toilet facilities: properly constructed, supplied, & cleaned			
54				Garbage & refuse properly disposed; facilities maintained			
55				Physical facilities installed, maintained, & clean			
56				Adequate ventilation & lighting; designated areas used			
57				Compliance with MCIAA			
58				Compliance with licensing & plan review			
Food Recalls:							
Person in Charge (Signature)							
Date: 11/19/24							
Inspector (Signature)							