



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 2, 2024

Licensee

Generations Home Care Inc
705 2nd Avenue South
Waite Park, MN 56387

RE: License Number 415064
Health Facility Identification Number (HFID) 32944
Project Number(s) SL32944015

Dear Licensee:

On November 19, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 7, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 2, 2024.

The Department of Health 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.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 18, 2024

Licensee

Generations Home Care Inc.

705 2nd Avenue South

Waite Park, MN 56387

RE: Conditional License Number 415064
Health Facility Identification Number (HFID) 32944
Project Number(s) SL32944015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 17, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,500.00. **MDH is not imposing these fines against your license at this time.**

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a

reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:

MDH will issue Generations Home Care Inc. a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Generations Home Care Inc. is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Generations Home Care Inc. will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Generations Home Care Inc. must provide the Department:
 - i. A list of the names and birthdates of any individuals Generations Home Care Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 1. Name and birthdate of each resident
 2. Physical location of each resident
 3. Current payment source for services
 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Generations Home Care Inc. will contract with an RN to provide consultation concerning all resident(s) to whom Generations Home Care Inc. provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Generations Home Care Inc. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Generations Home Care Inc. and MDH must review the RN’s credentials and approve the selection. Generations Home Care Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Generations Home Care Inc. in an effort to help Generations Home Care Inc. align their practices with the requirements of Minn. Stat. §§ 144G.01 –

144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Generations Home Care Inc. will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Generations Home Care Inc. and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Survey Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Generations Home Care Inc. to correct the violations cited during the survey as well as to determine the overall practice of Generations Home Care Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Generations Home Care Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

- i. A statement of the concern
- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Generations Home Care Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Generations Home Care Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Generations Home Care Inc.'s assisted living facility license, and Generations Home Care Inc. will correct any outstanding violations identified during the survey. If Generations Home Care Inc. is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 705 2ND AVENUE SOUTH WAITE PARK, MN 56387		
(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: SL32944015 On August 5, 2024, through, August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 resident(s); 6 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 6, 2024, issued for SL32944015-0, tag identification 2310. On August 7, 2024, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250			

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: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on August 5,	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 2024, at 9:30 a.m., licensed assisted living director (LALD)-B stated she was familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page three of the application), identified "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. - I attest to that the assisted living facility has provided services to at least one resident during the immediately proceeding license year as required by Minn. Stat. sect. 144G.17 (5) (opens in new window). Page 6 was electronically signed by the licensee on November 15, 2023. The licensee had an Assisted Living license, issued on February 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; and - medication and treatment management. As a result of this survey, the following orders	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 were issued under 0510, 0550, 0630, 0730, 1290, 1370, 1620, 1700, 1730, 1760, 1780, and 1890. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 2024, for the specific	0 480			

Minnesota Department of Health

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0 480	Continued From page 7	0 480			
	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.				
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee, without the option to opt out of meal(s). This had the potential to affect all residents of the facility.	0 485			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 705 2ND AVENUE SOUTH WAITE PARK, MN 56387			
(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
0 485	Continued From page 8 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract page 8, under E. Home Management Services, number 3, noted "Meal preparation includes three nutritious meals and 2 snacks each day. Modified diets may be prepared by staff with no extra cost for preparation; however, the resident shall be responsible for any specialty food items to accommodate the diet." On August 7, 2024, at 9:30 a.m., licensed assisted living director (LALD)-B stated all meals were included in the price of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510			

Minnesota Department of Health

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0 510	Continued From page 9 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel/ULP-G) observed to provide medication administration. 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 August 6, 2024, at 7:15 a.m., the surveyor observed ULP-G administer medications to R1 in the dining/kitchen area. ULP-G administered insulin to R1, returned to the desk where medications were set up for administration, placed the needle in the sharps container, returned R1's medication container to the cupboard and pulled out a container with another resident's medications. When asked, ULP-G stated she was done with R1's medications and was moving on to the next resident and picked up	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 a pen. When asked when she was trained to change her gloves, ULP-G stated she "usually" changed them between residents, but was nervous. At this time, ULP-G went to the kitchen, removed her gloves, and put on clean gloves. When asked if she was trained to do hand hygiene after removing gloves, she said she was not sure. At this time, the gloves were removed and hand hygiene performed. On August 6, 2024, at 9:20 a.m., licensed practical nurse (LPN)-C stated her expectation is gloves should be changed and hand hygiene (either hand sanitizer or hand washing) after removing gloves, before putting on clean gloves. The licensee's Hand Washing and Sanitizing policy dated August 1, 2021, noted proper hand hygiene should be completed before placing gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting	0 550			

Minnesota Department of Health

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0 550	Continued From page 11 suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at 10:05 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-B, and observed a bulletin board inside and to the right of the front door where the grievance procedure was posted. The procedure included the name and telephone number for the individual responsible for handling grievances, but lacked the email contact information. On August 6, 2024, at 2:50 p.m., LALD-B said the	0 550			

Minnesota Department of Health

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0 550	Continued From page 12 form lacked the email contact information and was not aware this was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 630			

Minnesota Department of Health

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0 630	Continued From page 13 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 being transferred from bed to the wheelchair. During this time, the surveyor observed R1 to be non-verbal and ULP-E and ULP-F stated R1 was non-verbal. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, and transfers. R1's IAPP dated October 1, 2022, noted R1 was unable to report abuse, neglect, and exploitation, and resident was susceptible to abuse from another individual, including other vulnerable adults. Interventions noted staff to monitor for signs or symptoms of abuse, neglect, exploitation and report to nurse promptly, and staff to monitor for signs or symptoms of abuse or neglect from others and report to nurse promptly. The IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse. On August 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-C stated the IAPP was a template and the same template was utilized for all residents, and no specific interventions were included for each	0 630			

Minnesota Department of Health

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0 630	Continued From page 14 individual resident when required. R2 R2's diagnoses included spina bifida (a birth defect where the spinal cord fails to develop properly). R2's Service Plan dated February 1, 2024, noted services including assistance with dressing, grooming, toileting, and medication administration. R2's MAARC reports noted the following: - January 9, 2024, at 1:00 p.m., "It is suspected that [R2] is self-harming as he practices his sexual preference for BDSM [a variety of sexual activity involving the use of physical restraints, the granting and relinquishing of control, and the infliction of pain]. Staff were assisting VA [vulnerable adult [R2], with cares and saw a large blood stain on his bedsheets. Staff found an oral thermometer in the bottom of [R2's] closet, that appeared to have blood on the thermometer stick. Staff also noticed that [R2's] rectum appeared to be bruised. When [R2] was asked if he was partaking in self-harm regarding BDSM practices, he denied it. [R2] stated he does not know anything about a thermometer. [R2] stated that he did not do anything to himself regarding his rectum. [R2's] legal Guardian and Generations nursing staff were notified and were instructed that [R2] be seen for emergency care to rule out bowel perforation or any other concern." - February 7, 2024, at 4:00 p.m., "VA [R2] went on an outing on the evening of 02/06/2024 and returned home around 10:30 p.m. [R2] was assessed on the morning of 02/07/2024 by staff who were completing his AM {sp} cares. [R2] had red buttocks and skin breakdown. [R2] states he	0 630			

Minnesota Department of Health

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0 630	Continued From page 15 does not know how it happened. [R2] has a history of participating in BDSM activities. It is suspected that [R2] was participating or doing BDSM (sexual practices) on himself. All items pertaining to BDSM related activities were removed from his possession per his legal guardianship request." - June 27, 2024, at 9:00 a.m., "When staff were completing VA, [R2], AM {sp} cares they found a wound on [R2's] buttocks/coccyx area. The wound measures 3x5 inches. [R2] had a shower 6/26/24 morning and the wound was not there at that time. [R2] went to the ER [emergency room] to be evaluated, which it was diagnosed as cellulitis. We suspect that [R2] was performing BDSM practices on himself, which would be self-inflicted wound. [R2] denies this; however, [R2] has a history of wounds in this area from likely using a paddle or other similar items on himself." R2's IAPP dated August 9, 2023, noted R2 was not at risk of self-abuse, and lacked identification of the self-harming practices and statements of the specific measures to be taken to minimize the risk of abuse. On August 7, 2024, at 9:20 a.m., CNS-A stated the IAPP lacked identification of the BDSM or specific measures to be taken to minimize the risk of abuse, and added he didn't think to add it and didn't think of it as a form of abuse. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted the licensee would develop an IAPP for each vulnerable adult that would contain statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630			

Minnesota Department of Health

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0 630	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel/ULP)-G.	0 650			

Minnesota Department of Health

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0 650	Continued From page 17 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-G started employment on April 17, 2020, under the comprehensive home care license and began providing assisted living services to residents of the facility on August 1, 2021. ULP-G's employee record lacked documented evidence of the following: - documentation of annual performance reviews that identified areas of improvement needed and training needs. On August 7, 2024, at 10:28 a.m., human resources manager (HRM)-H stated the annual performance review for 2024 was not in ULP-G's record and must have gotten missed. The licensee's Employee Records policy dated August 1, 2021, noted the employee record would include documentation of an annual performance review that identified areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			

Minnesota Department of Health

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0 680	Continued From page 18	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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all of the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a	0 680			

Minnesota Department of Health

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0 680	Continued From page 19 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: During the initial tour of the facility with licensed assisted living director (LALD)-B on August 5, 2024, at 10:05 a.m., the surveyor observed the facility to be a one level home with a kitchen, dining, sitting area and bedrooms. The Emergency Preparedness Book, dated reviewed on May 19, 2024, lacked the following required content: - must identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - must include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP to maintain an integrated response; - policy to address the development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - names and contact information for entities providing services under the agreement; and - exercises to test the plan at least twice per year. On August 7, 2024, at 9:40 a.m., LALD-B stated the above content was missing from the emergency preparedness plan, and said one drill had been completed on May 19, 2024.	0 680			

Minnesota Department of Health

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0 680	Continued From page 20 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October, 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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,	0 730			

Minnesota Department of Health

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0 730	Continued From page 21 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 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 all records of communication pertinent to the resident's services for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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0 730	Continued From page 22 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 being transferred from bed to the wheelchair. After receiving medications and breakfast, R1 left to his day programming. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's prescriber orders dated September 1, 2023, included a Dexcom sensor and transmitter (for monitoring blood glucose levels) and sliding scale insulin aspart (Novolog) at breakfast, lunch, and supper. For blood glucose between 151 - 250 add 1 unit, 251 - 350 add 2 units, 351 - 400 or more add 3 units. R1's prescriber orders dated November 21, 2023, included insulin aspart, inject 3 units at breakfast and 4 units with lunch and supper. On August 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A and licensed practical nurse	0 730			

Minnesota Department of Health

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0 730	Continued From page 23 (LPN)-C stated the insulin pen and the Dexcom receiver were sent with R1 each day he goes to the day program. CNS-A and LPN-C stated the day program documents the blood sugar and administration of insulin, but they do not send any documentation back with R1, so they are not sure that it is being done. The licensee's Resident Record - Information and Content policy dated August 1, 2021, noted the resident record must include: - health information, including medical history, allergies, and when the the provider is managing medication or treatments that require documentation and other relevant health records; and - all records of communication pertinent to the resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780			

Minnesota Department of Health

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0 780	Continued From page 24 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 7, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. Upon testing the smoke alarms, it was found that the smoke alarms in the facility were not	0 780			

Minnesota Department of Health

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0 780	Continued From page 25 interconnected. On August 7, 2024, at 1:30 p.m., LALD-B stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the 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	0 800			

Minnesota Department of Health

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0 800	Continued From page 26 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 August 7, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. The following was observed. GENERAL MAINTENANCE: Bedroom 2 had multiple locations where the drywall had been damaged. Holes and gouges were present on every wall surface. On August 7, 2024, at 11:30 a.m., LALD-B stated the resident who lived in that room had destructive behaviors and was planning to move out. LALD-B stated they understood the above-listed deficiencies and would fix them as soon as possible. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

Minnesota Department of Health

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0 810	Continued From page 27 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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, 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 28 has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 7, 2024, licensed assisted living director (LALD)-B 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 "9.06 Fire Policy", dated August 1, 2024, 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step and was only written for a shelter-in-place (SIP) fire safety strategy. The FSEP failed to include any procedures for how staff are to evacuate the building. 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. On August 7, 2024, at 1:30 p.m., LALD-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.	0 810			

Minnesota Department of Health

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0 810	Continued From page 29 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-B 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. LALD-B lacked documentation showing any training was completed or training was scheduled for a future date for staff on the fire safety and evacuation plan. On August 7, 2024, at 1:30 p.m., LALD-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910			

Minnesota Department of Health

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0 910	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents who resided in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract lacked the following required content: - physical mailing address (which may not be a post office box) of the licensee and authorized agent. On August 7, 2024, at 9:30 a.m., licensed assisted living director (LALD)-B stated the contract lacked the above required content, and contained a post office box for the mailing address. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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0 930	Continued From page 31 facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated September 11, 2023,	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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0 930	Continued From page 32 noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, and transfers. R1's Assisted Living Contract dated May 8, 2024, lacked the following required content: -the right under section 144G.54 to appeal the termination of an assisted living contract; and -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer. On August 7, 2024, at 9:30 a.m., licensed assisted living director (LALD)-B stated this information was not included in the old contract, and the new contracts revised after a recent survey had not been signed in this house. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
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	01060			

Minnesota Department of Health

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01060	Continued From page 33 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 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 and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R1).	01060			

Minnesota Department of Health

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01060	Continued From page 34 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's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, and transfers. R1's Progress Notes dated June 6, 2024, noted R1 was admitted to the hospital. R1's Progress Notes dated June 9, 2024, noted R1 returned from the hospital. R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - 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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01060	Continued From page 35 that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On August 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they were not aware of the requirement to provide this notice The licensee's Emergency Relocation policy dated August 1, 2021, noted in the event of an emergency relocation, the licensee would provide a written notice including the reason for the relocation, the name and contact information for the location to which the resident was relocated, contact information for OOLTC, the approximate date or range of dates within which the resident was expected to return to the facility or statement that the return date was not known, and a statement that if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. It noted this would be delivered as soon as practicable to the resident, legal representative and designated representative. It also noted the OOLTC would be provided the notice if the resident had not returned within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=E	144G.60 Subdivision 1 Background studies required	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01290	Continued From page 36 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees with access to residents and resident records had background studies affiliated with the assisted living facility for 2 of 13 employees (licensed practical nurse/LPN-C, unlicensed personnel/ULP-D). This had the potential to affect all residents, employees, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01290	Continued From page 37 LPN-C LPN-C was hired on June 22, 2021, to provide direct care services to residents of the facility. LPN-C's employee record contained a background study clearance letter dated June 22, 2021, submitted through a separate license of a sister company. Review of the NetStudy 2.0 noted LPN-C's affiliation date as August 5, 2024. ULP-D ULP-D was hired on March 23, 2022, to provide direct care services to residents of the facility. ULP-D's employee record contained a background study clearance letter dated April 5, 2022, submitted through a separate license of a sister company. Review of the NetStudy 2.0 noted ULP-D's affiliation date as August 5, 2024. On August 7, 2024, human resources manager (HRM)-H stated she had affiliated LPN-C and ULP-D on August 5, 2024, after the surveyor had requested the roster. The licensee's Background Studies policy dated February 24, 2023, noted "No employee may provide services and have independent direct contact with any residents until acceptable result of the background study have been received." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01370	Continued From page 38 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01370	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on March 15, 2024, to provide direct care services to residents of the facility. On August 6, 2024, at 7:05 a.m., the surveyor observed ULP-E assisting R1 with personal cares. ULP-E's employee record lacked documented evidence of the following required training: - maintenance of a clean and safe environment. On August 6, 2024, at 11:05 a.m., licensed assisted living director (LALD)-B stated she was unable to locate this training for ULP-E. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training and competency evaluations for all ULP would include maintenance of a clean and safe environment.	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01370	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
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 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01620	Continued From page 41 comprehensive reassessment using the uniform assessment tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted for services on January 9, 2020, with diagnoses including cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 being transferred from bed to the wheelchair. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's record contained an Assisted Living RN Assessment dated January 9, 2020, which indicated R1 was recommended for placement. R1's record contained untitled documents with the resident's name, date, as follows: - November 1, 2023, 90 day assessment, face-to-face/in person, service plan reviewed and	01620			

Minnesota Department of Health

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01620	Continued From page 42 no changes, abuse prevention plan reviewed with no changes. On January 15, 2023 a note was added to note "no changes to service plan. Has been seen in ER [emergency room] for UTI [urinary tract infection] and treated with antibiotics"; - April 10, 2024, 90 day assessment, face-to-face/in person, service plan reviewed with no changes, abuse prevention plan reviewed with no changes, and side rail use reviewed with no changes; and - July 5, 2024, 90 day assessment, face-to-face/in person, service plan reviewed with no changes, abuse prevention plan reviewed with no changes, and side rail use reviewed with no changes. On August 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated he had no completed assessment documented for R1, as he was in the process of changing his assessment forms after a survey at another site. CNS-A stated he was not currently reviewing the entire content of the uniform assessment tool with each assessment. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. The licensee's Assessments, Reviews & Monitoring policy dated July 26, 2022, noted the initial nursing assessment and reassessments must include all elements of the uniform assessment tool as required. No further information was provided.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01620	Continued From page 43	01620			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01700	Continued From page 44 registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) who received medication management services. 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: During the entrance conference on March 4, 2024, at 9:50 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 transferring from bed to the wheelchair. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's prescriber orders dated November 21, 2023,	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01700	Continued From page 45 included two insulin, one statin, and one anti-seizure medication. R1's Medication Administration Record for August 2024 included staff initials through August 5, 2024, to indicate R1 had received his prescribed medications. R1's record lacked a medication assessment to include: - identification and review of all medications the resident is known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On August 5, 2021, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated he had not completed a medication assessment with the required content, and added the prescriber had completed a list of medication with indications for all residents. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated prior to providing medication management services the RN would conduct an assessment to determine what services would be provided to include an identification and review of all medications the resident was taking, the indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address the issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01700	Continued From page 46 days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01730	Continued From page 47 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on March 4, 2024, at 9:50 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and	01730			

Minnesota Department of Health

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01730	Continued From page 48 ULP-F assist R1 transferring from bed to the wheelchair. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's prescriber orders dated November 21, 2023, included two insulin, one statin, and one anti-seizure medication. R1's Medication Administration Record for August 2024 included staff initials through August 5, 2024, to indicate the medications had been given. R1's record lacked a medication management plan to include: - a medication reconciliation. On August 5, 2021, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated he had not completed a medication reconciliation for any resident. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, noted medication reconciliation would be completed when a licensed nurse, licensed health professional or authorized prescriber was providing medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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01760	Continued From page 49 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per manufacturer instructions for one of one resident (R1); failed to ensure medications were documented after administration for one of one unlicensed personnel (ULP)-G; and failed to ensure medications were administered by the person completing the medication setup for one of one ULP (G). 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:	01760			

Minnesota Department of Health

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01760	Continued From page 50 ADMINISTRATION PER MANUFACTURER INSTRUCTIONS R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's prescriber orders dated September 1, 2023, included sliding scale insulin aspart (Novolog) at breakfast, lunch, and supper. For blood glucose between 151 - 250 add 1 unit, 251 - 350 add 2 units, 351 - 400 or more add 3 units. R1's prescriber orders dated May 14, 2024, included insulin aspart (Novolog) 100 units/milliliter (ml) 3 ml pen. Inject 4 units subcutaneously (SQ) before breakfast, 5 units before lunch, and 6 units before supper. On August 6, 2024, at 7:15 a.m., the surveyor observed ULP-G prepare R1's insulin aspart for administration. ULP-G obtained the glucometer reading of 257, dialed the insulin to 6 units, received a double check from ULP-F, wiped R1's abdomen, and administered the insulin. At this time, ULP-G stated she was not trained to prime the insulin pen by dialing to 2 units and wasting the liquid before dialing to the prescribed dose. The manufacturer's instructions for use of the Novolog FlexPen dated February 2023, instructed to turn the dose selector to select 2 units, tap the	01760			

Minnesota Department of Health

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01760	Continued From page 51 cartridge gently to make any air bubbles collect at the top of the cartridge and press the push-button when a drop of insulin should appear at the needle tip. At this point, turn the dose selector to the number of units to be injected. The licensee's Insulin Administration Insulin Pen protocol for R1 instructed staff to prime the insulin pen by turning the dose selector to 2 units, tapping the cartridge gently a few times, and press the button all the way in until the dose selector is back to 0. MEDICATION ADMINISTRATION DOCUMENTATION On August 6, 2024, at 7:15 a.m., the surveyor observed ULP-G prepare R1's medications for administration. ULP-G placed the medications in the medication cup and initialed the medication record prior to administration of the medications. After completion, ULP-G stated she "sometimes" signs off on the medications being administered prior to administration, and was not trained to do this. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated May 30, 2022, indicated the date, time, quantity of dose, method of administration, and signature or initial of the person providing the medication administration must be documented after providing medication administration. MEDICATIONS NOT ADMINISTERED BY PERSON COMPLETING THE MEDICATION SETUP On August 6, 2024, at 7:15 a.m., the surveyor observed ULP-G prepare R1's medications for	01760			

Minnesota Department of Health

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01760	Continued From page 52 administration. After all medications had been placed in the medication cup and initialed off, ULP-G brought the medications to the kitchen, dumped them into a bowl with oatmeal, and ULP-E stirred them into the oatmeal and administered the medications to R1. At this time, ULP-G stated sometimes she has other staff administer the medications she has setup because they are rushed in the morning, and added she was not trained to do the medication administration this way. On August 6, 2024, at 9:20 a.m., licensed practical nurse (LPN)-C stated it is her expectation the insulin pen be primed prior to dialing the prescribed dose, medication documentation should be completed after the medications had been administered, and must be administered by the staff setting up the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must	01780			

Minnesota Department of Health

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01780	Continued From page 53 be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. 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: During the entrance conference on March 4, 2024, at 9:50 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 being transferred from bed to the wheelchair. After receiving medications and	01780			

Minnesota Department of Health

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01780	Continued From page 54 breakfast, R1 left to his day programming. R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, blood glucose, and transfers. R1's prescriber orders dated September 1, 2023, included a Dexcom sensor and transmitter (for monitoring blood glucose levels) and sliding scale insulin aspart (Novolog) at breakfast, lunch, and supper. For blood glucose between 151 - 250 add 1 unit, 251 - 350 add 2 units, 351 - 400 or more add 3 units. R1's prescriber orders dated November 21, 2023, included insulin aspart, inject 3 units at breakfast and 4 units with lunch and supper. On August 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-C stated the insulin pen and the Dexcom receiver is sent with R1 each day he goes to the day program. CNS-A and LPN-C stated the day program documents the blood sugar and administration of insulin, but they do not send any documentation back with R1, so they are not sure that it is being done since no paperwork goes back and forth with R1. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated for planned time away, the medications must be obtained by the pharmacy or set up by a licensed nurse. It also noted it must include the following: - the resident must be provided written information on medications, including any special instructions for administering or handling the	01780			

Minnesota Department of Health

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01780	Continued From page 55 medications, including controlled substances; and - the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled; - the resident or representative must be provided in writing the facility's contact information; and - the process must be properly documented in the medication administration record including documenting the date the medications were given, who received the medications, the person who gave the medications, the number of medications given, and other required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications with an open date for one of one resident (R1). This practice resulted in a level two violation (a	01890			

Minnesota Department of Health

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01890	Continued From page 56 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: On August 5, 2024, at 2:40 p.m., the surveyor observed the medication cart with licensed practical nurse (LPN)-C. The following was observed and confirmed with LPN-C. R1's insulin aspart (Novolog) FlexPen 3 milliliter (ml) had a small sticker that had a space for date opened and date expires. However, both were left blank. At this time, LPN-C stated it was the expectation that staff date the insulin pens when they were opened. The manufacturer's instructions for use dated February 2023, instructed to throw away all opened insulin after 28 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02310 SS=I	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	02310			

Minnesota Department of Health

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02310	Continued From page 57 standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of three residents (R1) with a hospital bedrail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on August 6, 2024. R1's diagnoses included cerebral palsy, spastic quadriplegia, seizure disorder, kyphoscoliosis (abnormal curvature of the spine), and type 2 diabetes. On August 6, 2024, at 7:05 a.m., the surveyor observed R1 in his room, in a hospital bed with four bedrails in the raised position. The surveyor observed unlicensed personnel (ULP)-E and ULP-F assist R1 being transferred from bed to the wheelchair. The lower right bedrail was lowered before the lift was placed in position. The surveyor did not observe R1 attempt to use the rails for turning or repositioning when staff turned him to place the lift sling underneath him.	02310			

Minnesota Department of Health

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02310	Continued From page 58 R1's Service Plan dated September 11, 2023, noted services including complete assistance with dressing, eating, hygiene, grooming, toileting, bathing, medication administration, and transfers. R1's Assisted Living RN [registered nurse] Assessment dated January 9, 2020, noted R1 was totally dependent with transferring and mobility. R1's untitled form completed quarterly by the nurse included if the assessment was a 90 day, change of condition, done in person or via telecommunication, if the service plan was reviewed, whether the abuse prevention plan was reviewed, and whether the side rail use was reviewed. Side rail reviewed was marked yes on April 10, 2024, and go back at least quarterly to March 25, 2022. All other forms were marked no for the side rail use being reviewed. R1's Medical Necessity Screening for Use of Bed Side Rails dated March 20, 2023, noted: - R1 was non-ambulatory; - level of consciousness did not fluctuate; - no alteration in safety awareness due to cognitive decrease; - no history of falls; - no poor bed mobility or difficulty moving to a sitting position on the side of the bed; - has difficulty with balance or trunk control; - has not expressed a desire to have the bedrails raised while in bed for safety and/or comfort; - is not visually challenged; - indicated and serve as an enabler to promote independence; - the resident/family understands the risks of the side rail use and provided with bed safety pamphlet; - marked top half rails (top and bottom half rails was an option);	02310			

Minnesota Department of Health

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02310	Continued From page 59 - verified and comply with 2006 Food and Drug Administration (FDA) guidelines; and - measurements for zone 1 - 3.25 inches, zone 2 - 3 inches, zone 3 - 2 inches. Zone 4 had no measurements noted. On August 5, 2024, at :00 p.m., clinical nurse supervisor (CNS)-A stated the measurements were added after a survey at another facility, and were not there at the time of the assessment as dated. He stated bedrails are not assessed every 90 days with assessments for any resident. On August 6, 2024, at 11:00 a.m., the surveyor observed licensed practical nurse (LPN)-C measure R1's bedrails. Zone 1 measured between 2 1/4 to 3 1/2 inches. Zone 2 through Zone 4 measured zero. The rail went below where the mattress started and was tight against the mattress for zone 3. All four bedrails were the same, with eight metal bars vertically between the outer rail, the 6 inner rails were lower than the outer. All rails were tight except the upper left rail, which was slightly loose and able to be moved in and out and towards the foot and head of the bed easily. At this time, LPN-C stated R1 utilized the bedrails to keep from falling out of bed and for positioning. On August 6, 2024, at 11:10 a.m., CNS-A stated via phone interview, the Medical Necessity Screening tool and the Guide to Bed Safety form were emailed to R1's guardian, but not verbally reviewed with the guardian. He stated the bedrails were used for safety to prevent R1 from falling out of bed. On August 6, 2024, at 11:15 a.m., unlicensed personnel ULP-G stated the bedrails were used to prevent R1 from falling since he does move in	02310			

Minnesota Department of Health

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02310	Continued From page 60 bed and would fall out if they were not in place. ULP-E stated R1 does use the rails at times when they are turning him in bed. R1's record lacked: - assessment of the cognitive and physical status; - risk for entrapment; - incontinence needs; - pain; - whether the bedrail had the effect of being an improper restraint; - zone 4 measurement; - whether the bedrail was securely attached per manufacturer recommendations; - an assessment every 90 days or with changes; and - physical inspection for areas of entrapment, stability, and correct installation. The licensee's Side Rails (bedrails) policy dated March 6, 2023, noted "Due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. The resident/responsible party will be educated regarding the risks and benefits of physical devices. Continued use of physical devices will be assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress),	02310			

Minnesota Department of Health

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02310	Continued From page 61 should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The 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 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." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy of this order was removed on August 7, 2024, however, non-compliance remains at a level and scope of level three, widespread (I).	02310			



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

Type: Full
Date: 08/05/24
Time: 10:30:12
Report: 1037241177

Food and Beverage Establishment Inspection Report

Page 1

Location:

Generations Home Care Inc
705 2nd Avenue South
Waite Park, MN56387
Stearns County, 73

Establishment Info:

ID #: 0038029
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202828074
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.

FOODS IN THE UPRIGHT COOLER MEASURED: EGGS 48, SLICED HAM 49, IMMITATION CRAB 51.
DISCARD TCS FOODS AND MAINTAIN A TEMPERATURE OF 41 OR BELOW IN THE UPRIGHT COOLER.

Comply By: 08/05/24

3-700 Contaminated Food: discarded

3-701.11A **** Priority 1 ****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

DISCARD IMPROPERLY COLD HELD FOODS IN UPRIGHT COOLER: MILK, HAM, IMITATION CRAB, CHEESE.

Comply By: 08/05/24

4-500 Equipment Maintenance and Operation

4-501.114C1 **** Priority 1 ****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

CHLORINE SANITIZER IN THE DISHWASHER MEASURED 0PPM. REPAIR DISHWASHER AND ENSURE A CONCENTRATION OF AT LEAST 50PPM CHLORINE.

Comply By: 08/05/24

Type: Full
Date: 08/05/24
Time: 10:30:12
Report: 1037241177
Generations Home Care Inc

Food and Beverage Establishment Inspection Report

Page 2

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.

LARGE DIAMETER STEW THERMOMETERS WERE PRESENT. PROVIDE A THIN TIP THERMOMETER FOR TAKING TEMPERATURES OF THIN FOODS (EX: CHICKEN BREAST, BURGERS).

Comply By: 08/12/24

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.

CHLORINE AND QUAT SANITIZERS ARE USED ON SITE. PROVIDE TEST KITS FOR BOTH SANITIZERS.

Comply By: 08/12/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

LABEL CONTAINERS OF CEREAL WITH COMMON NAME ONCE REMOVED FROM ORIGINAL PACKAGING.

Comply By: 08/05/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

DURING TIME OF INSPECTION, NO THERMOMETER WAS OBSERVED IN THE FRIDGE. OBTAIN A THERMOMETER AND PLACE IN THE WARMEST PART OF THE FRIDGE.

Comply By: 08/12/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

UPRIGHT COOLER WAS MEASURING 48F ON DIGITAL DISPLAY. FOODS INSIDE MEASURED 48-51F, REPAIR COOLER TO ENSURE A TEMPERATURE OF 41 OR BELOW.

Comply By: 08/05/24

Surface and Equipment Sanitizers

Type: Full
Date: 08/05/24
Time: 10:30:12
Report: 1037241177
Generations Home Care Inc

Food and Beverage Establishment Inspection Report

Page 3

Chlorine: = 0PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Chlorine: = 200PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER WIPES BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 48 Degrees Fahrenheit - Location: EGGS
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 49 Degrees Fahrenheit - Location: SLICED HAM
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 51 Degrees Fahrenheit - Location: IMITATION CRAB
Violation Issued: Yes

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

ROUTINE INSPECTION AT GENERATIONS HOME CARE.

DISCUSSED DISPOSAL OF IMPROPERLY COLD HELD FOODS.

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 1037241177 of 08/05/24.

Certified Food Protection Manager: Tammy L. Schmidt

Certification Number: 7387 Expires: 06/04/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed:  _____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1037241177		Food Establishment Inspection Report					
	Minnesota Department of Health Food, Pools, and Lodging PO Box 64975 St. Paul, MN 55164		No. of RF/PHI Categories Out		3	Date 08/05/24	
			No. of Repeat RF/PHI Categories Out		0		
			Legal Authority MN Rules Chapter 4626				
Generations Home Care Inc		Address 705 2nd Avenue South		City/State Waite Park, MN		Zip Code 56387	Telephone 3202828074
License/Permit # 0038029		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	X			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	X			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: 08/05/24							
Inspector (Signature)							