Electronically Delivered
April 25, 2024

Licensee
Gabby Care Homes, LLC - Faith's House
1513 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36011015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: SL36011015-0 On April 9, 2024, through April 11, 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 two residents, both of whom received services under the Assisted Living license.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 11, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	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	0 650		

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0 650	Continued From page 2 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 employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 650		

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0 650	Continued From page 3 ULP-B was hired on May 10, 2021, to provide direct care to residents. ULP-E was hired December 15, 2020, to provide direct care to residents. ULP-B and ULP-E's employee records lacked a competency evaluation for setting up medications for an unplanned time away from home. On April 10, 2024, at 9:33 a.m., ULP-B stated the ULP did set up medications for residents when they left on a leave of absence. ULP-B explained the procedure for setting up medications and stated they were trained and received a competency evaluation by CNS-C prior completing their first resident unplanned time away from home medication set up. On April 20, 2024, at 11:16 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated when a resident had a planned time away the pharmacy preset medications for the resident and then the ULP would provide the preset medications to the resident or the resident representative. For unplanned time away, staff were trained to send up to three days of medications with the resident and there was a step-by-step instruction for the ULP to follow on RTasks (a documenting software system). Clinical nurse supervisor (CNS)-C stated they trained the ULP on time away from home by using a step by step print out. The surveyor inquired if the licensee had documentation of training or competencies related to setting up medications for an unplanned time away. LALD/RN-D stated they had documentation from a meeting, and they believed competencies would be in the office.	0 650		

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0 650	Continued From page 4 On April 10, 2024, at 12:17 p.m., LALD/RN-D provided the surveyor with the training for setting up medications for an unplanned time away. CNS-C stated they did complete a competency evaluation on all ULP for setting up medication for an unplanned time away however, they did not document the competency evaluation for all ULP. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2022, indicated for unplanned time away, when the pharmacy was not able to provide the medication, a licensed nurse or a properly trained and competency tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee record for each employee would include verification of completed orientation, annual training, and competency testing as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 5 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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:	0 680		

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0 680	Continued From page 6 The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; -subsistence needs for staff and patients to include sewage and waste disposal; - roles under a waiver declared by secretary; and - emergency officials contact information to include state licensing and certification agency and Minnesota Office of Ombudsman for long term care. On April 10, 2024, at 9:01 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the licensee reviewed the missing resident policy twice per year, and they were not aware it needed to be reviewed quarterly. On April 10, 2024, at 11:03 a.m., LALD/RN-D and clinical nurse supervisor (CNS)-C verified the EPP lacked the content listed above. CNS-C stated they were not familiar with the content listed above for the EPP and the licensee would update the EPP to include the content listed above. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee EPP would include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01500 SS=D	144G.63 Subd. 5 Required annual training	01500		

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01500	Continued From page 7 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01500		

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01500	Continued From page 8 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of two employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-A was hired on February 25, 2020, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents.	01500		

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01500	Continued From page 9 RN-A's employee record included reporting maltreatment of vulnerable adults, review of policy and procedures, and two hours and 45 minutes of dementia care training completed in 2023. RN-A's employee record lacked eight hours of annual training completed within the last 12 months for: - infection control; - assisted living bill of rights; and - principles of person-centered planning/service delivery. On April 9, 2024, at 12:43 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the licensee used EduCare (a training software) to complete all annual training. LALD/RN-D stated they loaded EduCare's courses listed on the document titled Assisted Living & Memory Care Annual Training Checklist-LALD (licensed assisted living director) for themself and for RN-A which included two hours of dementia training and emergency disaster preparedness plan however, the document lacked the content listed above. On April 9, 1:02 p.m., LALD/RN-D stated they accidently used EduCare's LALD checklist to upload education for RN-A. The surveyor inquired if LALD/RN-D performed direct cares on residents since they were a RN. LALD/RN-D stated yes. The surveyor inquired if they completed the required annual training listed above for themself. LALD/RN-A stated no and verified they lacked the annual training listed above. The licensee's 5.06 Annual Required Staff Training dated August 1, 2021, indicated all staff that performed direct care services for the licensee would complete at least eight hours of	01500		

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01500	Continued From page 10 annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of two residents (R1) on or before the admission date. This practice resulted in a level two violation (a	01610		

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01610	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on February 1, 2024, and began receiving assisted living services. R1's diagnosis included schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder) and bipolar (mental health condition characterized by extreme mood swings). R1's Service Plan (Waiver)-Addendum to Contract signed February 4, 2024, indicated R1 received assistance with bathing reminders, behavior management, housekeeping, laundry, medication administration, monitoring of oxygen and temperature, safety checks, and shopping assistance. R1's record included a Pre-Admission Assessment completed on February 5, 2024, five days after admission. R1's record also included an Admission Assessment completed on February 5, 2024, five days after admission. On April 9, 2024, at 8:15 a.m., during entrance conference, clinical nurse supervisor (CNS)-C stated the licensee completed resident	01610		

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GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

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01610	Continued From page 12 assessments prior to admission and/or on admission, day 14, every 90 days, and with change of condition. On April 9, 2024, at 12:43 p.m., CNS-C confirmed R1's admission date of February 1, 2024. CNS-C stated the licensee conducted a preadmission assessment prior to R1's admission to the facility, however, they did not "lock" the assessment in RTasks (a documenting software) causing the document to show it was completed late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the licensee would conduct a nursing assessment by a RN of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		

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

Type: Full
Date: *04/11/24*
Time: 15:45:02
Report: 1039241108

Food and Beverage Establishment Inspection Report

Location:
Gabby Care Homes Llc - Faith'S
1513 Pennsylvania Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038385
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124813138
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.

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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

SHELL EGGS STORED OVER PRODUCE IN REFRIGERATOR. EGGS MOVED TO BOTTOM SHELF TO COMPLY WITH ABOVE.

Corrected on Site

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DAIRY MILK OPENED MORE THAN 24 HOURS PRIOR TO INSPECTION LACKS A DATE MARK. DATE MARK ADDED TO COMPLY WITH ABOVE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

STAFF MEMBER IS ATTEMPTING TO SERVE AS CFPM FOR MORE THAN ONE HOME. A STAFF MEMBER MAY NOT SERVE AS CFPM FOR MULTIPLE LOCATIONS. EACH HOME MUST HAVE ITS OWN CFPM.

Comply By: 06/06/24

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

Process/Item: FREEZER
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Ashely Crews.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate wood floor, painted walls with popcorn ceiling and smooth countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Dish machine is rated "NSF Residential" and achieves utensil surface temperature >150 degrees F per color-change thermo test strip.

A thin-probe food thermometer is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, handwashing, sanitizing.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241108 of 04/11/24.

Certified Food Protection Manager: Joy Moraby

Certification Number: FM110188 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Samuel Obwaya
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us