Electronically delivered

March 24, 2022

Administrator
Gabby Care Homes, LLC
1500 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL35601015

Dear Administrator:

On March 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on January 6, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the January 6, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 6, 2022, found not corrected at the time of the March 15, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

The details of the violations noted at the time of this follow-up evaluation completed on March 15, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35601	A. BUILDING: _____ B. WING _____	R 03/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA H	1500 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL35601015 On March 15, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed January 6, 2022. At the time of the survey, there were eight (8) residents receiving services under the Assisted Living license. As a result of the revisit the following order was reissued: 1760. The provider is in substantial compliance.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (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: (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: No further action required	{0 480}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}		

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{0 790}	Continued From page 2 This MN Requirement is not met as evidenced by: No further action required	{0 790}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication 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 interview and record review, the licensee failed to ensure medications were administered according to prescriber instructions for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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).	{01760}		

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{01760}	Continued From page 4 The findings include: R1's carvedilol (antihypertensive) was not administered according to prescriber instructions. R1's diagnoses included, but was not limited to hypertension (high blood pressure) and congestive heart failure. R1's Service Plan, dated January 10, 2022, indicated the resident received medication management services to include medication administration. R1's record included a prescriber order, dated June 29, 2021, that indicated carvedilol 12.5 mg (milligram) one tablet twice daily with a meal, and hold medication if heart rate is less than 55 BPM (beats per minute) or systolic blood pressure is less than 100. R1's medication administration record (MAR) for February 2022 and March 1 through March 14, 2022, indicated carvedilol was administered to R1 twice daily. The MAR included the instructions, "HOLD MEDICATION IF HEART RATE IS LESS THAN 55 BPM OR BLOOD PRESSURE IS LESS THAN 100/60 RECORD BLOOD PRESSURE IN THE REQUIRED NOTE". The MAR notation on February 15, 2022, included an 8:00 a.m. blood pressure reading of 144/101, and on March 8, 2022, R1 had declined to have a blood pressure taken. No other blood pressure or heart rate documentation was present in the MAR. R1's vitals signs report, dated February 15-March 15, 2022, indicated blood pressure readings were recorded at 8:00 a.m., one time daily, on February 17, 19, 21, 24, 26, and 28, and March 3, 5, 7, 10, 12, and 14 (12 out of 56 expected	{01760}		

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{01760}	Continued From page 5	{01760}		

entries). One heart rate reading was recorded at 8:00 a.m. on February 17, 2022 (1 out of 56 expected entries).

On March 15, 2022, at 11:09 a.m. the director of nursing (DON)-A stated the blood pressure and heart rate readings should have been listed on the vital Signs report provided. DON-A verified the documentation lacked several blood pressure and heart rate readings.

On March 15, 2022, at 12:31 p.m. unlicensed personnel (ULP)-D verified he provided medications to R1. ULP-D indicated he took vital sign readings for R1 in the mornings to include temperature, and oxygen saturation. ULP-D denied knowledge of any medication that required a blood pressure or heart rate reading prior to administration. ULP-D stated R1 does not refuse any cares, but acknowledged R1 might refuse cares from other caregivers.

On March 15, 2022, at 12:38 p.m. DON-A acknowledged more staff education would be necessary.

The licensee's 7.15 Medication and Treatment - Administration and Delegation policy dated August 1, 2021, noted the registered nurse would educate ULP that medications must be administered according to the prescriber orders, documented after administration, or if unable to administer the medication as prescribed.

No further information was provided.

Electronically Delivered

January 26, 2022

Administrator
Gabby Care Homes LLC - Cilla H
1500 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL35601015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 6, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

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

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

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

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING 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 has 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: SL35601015 On January 4, 2022, through January 6, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were seven (7) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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: (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 had the potential to affect all of the licensee's seven current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected 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 January 5, 2022, for the specific Minnesota Food	0 480		

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0 480	Continued From page 2 Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 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 ensure infection control standards were followed for two of two employees (unlicensed personnel (ULP)-C, ULP-D) providing personal cares. In addition, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect all seven residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	0 510		

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0 510	Continued From page 3	0 510		

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:

PERSONAL PROTECTIVE EQUIPMENT (PPE)
On January 5, 2022, at approximately 7:15 a.m. upon entrance to the facility, ULP-C was observed in resident care areas to wear a medical-grade mask and no eye protection. At approximately 7:17 a.m. ULP-C was observed to assist R1 with dressing, grooming and toileting. At approximately 7:50 a.m. ULP-C was observed to administer R1's morning oral medications. ULP-C wore a medical-grade mask and her own eyeglasses.

On January 5, 2022, at approximately 8:55 a.m. ULP-D was observed to assist R3 with administration of R3's morning medications. ULP-D wore a fabric grade face mask and his own eyeglasses.

On January 5, 2022, at approximately 12:45 p.m. director of nursing (DON)-A confirmed staff were not wearing appropriate eye protection. DON-A stated staff were aware eye protection was still a requirement, the licensee had adequate supplies, and all ULP were instructed to wear while providing any resident care services.

According to the COVID-19 Integrated County View, on January 3, 2022, Hennepin county (this facility's county) was identified as having a high transmission level.

The MDH document titled The COVID-19 Personal Protective Equipment and Source

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA H	1500 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
0 510	Continued From page 4 Control Grids dated December 7, 2021, indicated for counties with a high transmission level eye protection should be worn when working with residents with or without COVID-19 infection. The CDC COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient (resident) care encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 5 This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to ensure and maintain a current comprehensive tuberculosis (TB) infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. In addition. the licensee failed to ensure completion of baseline TB screening at the time of hire for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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). Findings include: The licensee's most current TB facility risk assessment dated December 1, 2021, noted a low risk. ULP-C was hired on March 20, 2019. ULP-C's employee record lacked documentation of a previous positive TB screen, and testing for the presence of mycobacterium tuberculosis by administering a two-step tuberculin skin test, or a single blood test. ULP-C's employee record included a nurse practitioner note dated October 10, 2018, "Chest Xray - no evidence of TB" (five	0 660		

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0 660	Continued From page 6 months prior to hire date). On January 5, 2022, at 1:25 p.m. administrator (A)-B confirmed ULP-C's employee record lacked evidence of required TB baseline screening completed at the time of hire. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, noted each new employee would complete baseline TB screening at the time of hire prior to provision of resident care services. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 7 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content. This had the potential to affect all residents receiving services under the Assisted Living license. 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	0 680		

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0 680	Continued From page 8 has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 5, 2022, at approximately 3:05 p.m. the surveyor requested the licensee's emergency disaster preparedness plan. Director of nursing (DON)-A provided the Gabby Homes Emergency Preparedness Procedures manual posted in the assisted living facility for review. The licensee's written emergency plan identified several natural emergency events (such as fire, tornado, and winter storm) with basic information related to tasks for staff to implement in the event of a specific emergency event. The licensee's plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics. - a process for emergency preparedness (EP) cooperation with state and local EP officials and organizations; - a current resident roster form for tracking residents. - development of policies/procedures to address: - evacuation plan (not customized for the facility). - fire (not customized for the facility). - a tracking system used to document locations or residents and staff. - the medical record documentation system to preserve resident information. - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - EP training and testing program. - EP training program for staff (including	0 680		

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0 680	Continued From page 9 documentation of training provided); and - EP testing/annual testing requirements. On January 5, 2022, at approximately 3:10 p.m. DON-A confirmed he nor other management staff were familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the guidelines). A-B verified the licensee had not fully developed and implemented the facility's EP plan/program. The licensee's 19.02 Emergency Plan policy dated August 1, 2021, noted the licensee would complete and retain a current EP plan to include the above required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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0 790	Continued From page 10 by: Based on observation and interviews the facility failed to ensure installation and maintenance of portable fire extinguishers on-site. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the building tour on January 06, 2022, with the registered nurse (RN)-A and the administrator (A)-B, the surveyor observed the facility did not have the correct size fire extinguishers. RN-A and A-B confirmed fire extinguishers were recently replaced by their third-party contractor and they had requested the wrong size. RN-A stated they will get the correct size ordered immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 11 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 12 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: On January 06, 2021, at approximately 11:00 a.m., the surveyor requested the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, to review if available. Upon review the following items were not documented: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No record of required employee evacuation drills. Administrator (A)-B and registered nurse (RN)-A confirmed documentation of fire safety and evacuation policy and procedures were incomplete. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 13 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide employee dementia care training (at least eight hours within 160 working hours of the employment start date), on required topics for one of two employees (unlicensed personnel (ULP)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 14	01530		

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).

Findings include:

ULP-D started employment on April 30, 2021, under the Comprehensive Home Care license and began providing assisted living facility services on August 1, 2021.

ULP-D's employee record did not contain documentation of completed initial eight hours of training required related to dementia care, within 160 working hours of ULP-D's employment start date.

On January 5, 2021, at 1:15 p.m. director of nursing (DON)-A verified ULP-D had provided assisted living direct care services to the licensee's residents, and worked more than the above listed hours since beginning employment. DON-A confirmed ULP-D had not completed eight hours of training related to dementia care training in the required time frame. ULP-D's employee record contained documentation of on-line dementia training completed for five and a half hours.

The licensee's 5.03 Dementia Training policy dated August 1, 2021, noted each new employee would complete eight hours of dementia care training, at the time of hire within 160 hours of employment start date for direct care staff, and within 120 working hours of the employment start date for supervisors of direct care staff. The

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01530	Continued From page 15 policy language noted the required training topics and content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01530		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was signed or authenticated for one of one resident	01640		

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01640	Continued From page 16 (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 received services to include medication management and assistance with behavior management, meals, laundry and housekeeping. R1's service plan was undated, signed by the administrator (A)-B and lacked a signature of the resident or resident's representative. On January 6, 2021, at 10:45 a.m. A-B confirmed R1's service plan lacked a date she signed it and did not document a signature or authentication by the resident. A-B stated she was aware of the requirement for a dated service plan, with signature or authentication by the licensee and resident or by the licensee's representative. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions to service plans would be dated, and have a signature or other authentication by the provider and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01760	Continued From page 17	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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 according to prescriber instructions for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: The findings include:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35601	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA H	1500 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
01760	Continued From page 18	01760		

R1's carvedilol (antihypertensive) was not administered according to prescriber instructions.

R1's diagnoses included, but was not limited to hypertension (high blood pressure) and congestive heart failure.

R1's undated Service Plan indicated the resident received medication management services to include medication administration. R1's Assessment and medication management plan dated October 22, 2021, indicated R1 required medication set up, administration, reordering supplies, due to anxiety and unspecified psychosis.

R1's prescriber order dated December 2, 2021, noted carvedilol 12.5 mg (milligram) one tablet twice daily with a meal, and hold medication if heart rate is less than 55 BPM (beats per minute) or systolic blood pressure is less than 100.

On January 5, 2022, at approximately 8:00 a.m. unlicensed personnel (ULP)-C was observed to visually check R1's electronic January 2022, medication administration record (MAR) for prescribed oral medications to setup and administer. ULP-C obtained the medications from pharmacy printed and monthly issued blister packs and emptied them into a small paper medication cup. ULP-C then entered R1's bedroom and administered the oral medications, without taking R1's blood pressure or heart rate.

On January 5, 2022, at approximately 8:35 a.m. ULP-C confirmed printed instructions related to administration of carvedilol were in R1's January 2022, MAR. ULP-C confirmed he had not taken R1's blood pressure or heart rate as the resident had previously refused many times, so he did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35601	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA H	1500 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
01760	Continued From page 19 complete the task. On January 5, 2022, at approximately 2:30 p.m. director of nursing (DON)-A confirmed ULP-C should have taken R1's blood pressure and heart rate prior to administration of the carvedilol. DON-A also stated the ULP should have documented the reason why he was not able to complete the task in the resident record and notify the nurse. The licensee's 7.15 Medication and Treatment - Administration and Delegation policy dated August 1, 2021, noted all medications must be administered according to the prescriber orders, documented after administration, and the ULP were to notify a nurse if unable to administer the medication as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health

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

Type: Full
Date: *01/05/22*
Time: 10:00:00
Report: 8087221001

Food and Beverage Establishment Inspection Report

Location:
Gabby Care Homes Llc - Cilla H
1500 Pennsylvania Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038511
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634329109
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

Type: Full
Date: *01/05/22*
Time: 10:00:00
Report: 8087221001
Gabby Care Homes Llc - Cilla H

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR MARY CARROLL (HRD SURVEY SENIOR SUPERVISOR).

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, BUT NOT EASILY CLEANABLE OR SMOOTH (POPCORN STYLE CEILING TEXTURE). ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

LG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 127 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR MARY CARROLL (HRD SURVEY SENIOR SUPERVISOR).

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 8087221001 of 01/05/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
RONALD CHWEYA
RESIDENT CAREGIVER

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us