Electronically Delivered

October 21, 2024

Licensee
Generations Home Care Inc.
2616 1st Street North
Waite Park, MN 56387

RE: Project Number(s) SL33364015

Dear Licensee:

On October 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 3, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

July 26, 2024

Licensee
Generations Home Care Inc.
2616 1st Street North
Waite Park, MN 56387

RE: Project Number(s) SL33364015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 3, 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 . . ."

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

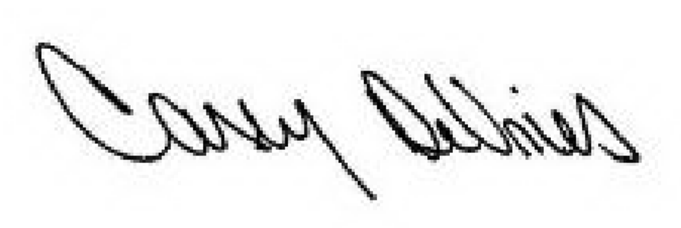
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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.u
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33364	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	2616 1ST STREET NORTH 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: SL33364015-0 On July 1, 2024, through July 3, 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 six residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on July 2, 2024, issued for SL33364015-0, tag identification 1290. On July 2, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on July 2, 2024, issued for SL33364015-0, tag identification 2310.	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.	

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0 000	Continued From page 1 On July 3, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000		
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) 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 July 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update emergency preparedness plan (EPP) annually. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 3 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: The licensee's Emergency Preparedness Plan was last updated on May 15, 2023. The EPP plan lacked annual update which was due on May 15, 2024. On July 3, 2024, at approximately 11:30 a.m., licensed assisted living director (LALD)-D stated they were aware of the requirement to update the EPP annually and stated they missed updating the plan in May 2024. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z dated august 1, 2021 read, "[name of licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 4	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On July 03, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. It was observed that the licensee did not have any documentation of the annual maintenance records of the autocall fire	0 800		

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0 800	Continued From page 5 alarm system and sprinkler system. During interview on July 03, 2024, at 1:00 p.m. LALD-D stated they did not have any records of the autocall fire alarm system and sprinkler system being inspected in the past twelve (12) months. LALD-D stated they did not know when the last time the systems were inspected but thought it had been a few years. 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, 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	0 810		

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0 810	Continued From page 6 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 training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 03, 2024, the licensed assisted living director (LALD)-D 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 08/01/2021, failed to include the following:	0 810		

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0 810	Continued From page 7 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have smoke compartments or fire doors. 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. During an interview on July 03, 2024, at 1:00 p.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-D was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. During an interview on July 03, 2024, at 1:00 p.m., LALD-D stated they were providing training to residents at intake but did not have any documentation to show that. LALD-D stated they understood the areas of their training that were insufficient and would work on bringing them into	0 810		

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0 810	Continued From page 8 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced	0 950		

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0 950	Continued From page 9 by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for one of six residents (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) 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: R1's Assisted Living Contract was signed on April 16, 2024. The licensee's Assisted Living Contract form utilized for R1, and the blank Assisted Living Contract form utilized for all residents, lacked the required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On July 3, 2024, at 11:20 a.m., licensed assisted living director (LALD)-D stated they were not aware of the requirement to include "right to designate a representative for certain purposes" notice in the assisted living contract and on a document separate from the contract. LALD-D also stated the same assisted living contract form was used for all residents. No further information was provided.	0 950		

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0 950	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=G	144G.60 Subdivision 1 Background studies required (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 a background study (BGS) was submitted and received in affiliation with the assisted living license for one of seventeen employees (unlicensed personnel (ULP)-C). 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 an isolated scope (when one or a limited number of residents are affected or one or	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 11 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP- C was hired on January 7, 2024, to provide direct cares and services to residents. The licensee's Generation Home Care Payroll Detail form dated April 10, 2024, to April 24, 2024, indicated ULP- C worked an evening shift on April 13, 2024, from 4:00 p.m., to 11:00 p.m. ULP-C's employee record included a Background Study Clearance Notice dated April 5, 2023. The licensee's NETstudy 2.0 did not include ULP-C in the list of employees whose BGS was affiliated to the licensee's HFID 33364. A screenshot taken from department of human services NETstudy 2.0 website on July 2, 2024, indicated ULP-C was separated from HFID 33364 on April 5, 2023. On July 2, 2024, at 9:24 a.m., licensed assisted living director (LALD)-D stated ULP-C used to work fulltime for the licensee, ULP-C quit and rehired on January 7, 2024, and the human resource department forgot to re-run the background study upon rehiring the ULP. LALD-D also stated ULP-C could pick up a night shift where they might work alone. On July 2, 2024, at 10:12 a.m., LALD-D stated ULP-C was working unsupervised as LALD-D was not aware ULP-C was missing a BGS clearance until today. The licensee's Background Studies Policy dated	01290		

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01290	Continued From page 12 February 24, 2023, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the BGS have been received. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On July 2, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. In addition, based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for two of seventeen employees (ULP-A, ULP-F). The findings include: ULP-A ULP- A was hired on January 16, 2024, to provide direct cares and services to residents. The licensee's staffing schedule for June 30, 2024, through August 3, 2024, indicated ULP-A was scheduled to work, dayshifts (7:00 a.m. to 3:00 p.m.) for the following dates: July 1, 2024, and July 29, 2024. ULP-A's employee record included a letter from the Department of Human Services dated February 8, 2024, which indicated the employee was clear to work under a sister facility's HFID 36691. The licensee lacked evidence ULP-A was affiliated to the licensee's HFID 33364 and was not included on the NETstudy 2.0 roster provided.	01290		

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01290	Continued From page 13 ULP- F ULP- F was hired on September 22, 2021, to provide direct cares and services to residents. The licensee's staffing schedule for May 26, 2024, through June 29, 2024, indicated ULP-F was scheduled to work, dayshifts (7:00 a.m. to 3:00 p.m.) for the following dates: May 28, 2024, May 31, 2024, June 1, 2024, June 2, 2024, June 15, 2024, and June 16, 2024. ULP-F's employee record included a letter from the Department of Human Services dated November 1, 2022, which indicated the employee was clear to work under a sister facility's HFID 35678. The licensee lacked evidence ULP-F was affiliated to the licensee's HFID 33364 and was not included on the NETstudy 2.0 roster provided. On July 3, 2024, at 11:14 a.m., LALD-D stated ULP-A and ULP-F's BGS were submitted at the ULP's primary workplace, LALD-D also stated they were not aware they had to affiliate the ULP's BGS to the current HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01620		

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01620	Continued From page 14 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minn Rule 4659.0150 and within the required time frames for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01620		

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01620	Continued From page 15 R1 and R3's records lacked 14-day assessments, ongoing 90-day assessments, evidence that an initial assessment was completed for R1, and evidence that assessments included the following required uniform assessment tool content: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; B. activities of daily living, including: (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) eating, dental status, oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living, including: (1) ability to self manage medications; (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; (3) infectious conditions;	01620		

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01620	Continued From page 16 (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication; (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post acute care facility; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; (7) weight; and (8) initial vital signs if indicated by health conditions or medications; E. emotional and mental health conditions, including: (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders;	01620		

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01620	Continued From page 17 (2) current symptoms of mental health conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; F. cognition, including: (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability; G. communication and sensory capabilities, including: (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; H. pain, including: (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and nonmedication alternatives; I. skin conditions; J. nutritional and hydration status and preferences; K. list of treatments, including type, frequency, and level of assistance needed; L. nursing needs, including potential to receive nursing-delegated services; M. risk indicators, including: (1) risk for falls including history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses;	01620		

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01620	Continued From page 18 (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; N. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and O. the need for follow-up referrals for additional medical or cognitive care by health professionals. R1 R1 was admitted to the licensee on December 30, 2018. R1's record included a checklist form entitled [licensee's name] which indicated a check mark next to "90-day assessments" dated June 30, 2024, identified by RN-E as R1's most recent 90-day assessment. The assessment form did not include uniform assessment tool content. The form included a check mark next to assessment type, a checkmark next to service plan reviewed and updated, a check mark next to abuse prevention plan reviewed and updated, and a check mark next to side rail use reviewed. R1's record also lacked evidence to indicate an initial assessment and a 14-day assessment were completed upon admission and within 14 days of admission.	01620		

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01620	Continued From page 19 R3 R3 was admitted to the licensee on December 5, 2022. R3's record included initial assessment dated December 2, 2022, and checklist form entitled [licensee's name] which indicated a check mark next to "90-day assessments" dated June 30, 2024, identified by RN-E as R3's most recent 90-day assessment. The assessment form did not include uniform assessment tool content. The form included a check mark next to assessment type, a checkmark next to service plan reviewed and updated, a check mark next to abuse prevention plan reviewed and updated, and a check mark next to side rail use reviewed. R3's record also lacked a 14-day assessment which was due on or before December 19, 2022. On July 1, 2024, at approximately 1:30 p.m., registered nurse (RN)-E stated they did not remember if they did an initial assessment for R1, "It was so long ago, I do not remember". RN-E stated they went to R1's previous house (provider) and talked to the people who cared for R1. RN-E stated, "I did not have that documented because the old rule did not require any of that. But I think when a new rule came into effect, I think I may have done a new assessment, I believe, I did a new abuse prevention plan, the medication assessment, and the therapy portion." RN-E stated they came in every 90 days to review abuse prevention plans, service plans, and if there was any change and bed rails. The surveyor inquired how 90-day assessments were conducted, and RN-E stated they filled out the checklist with four questions for all residents (referring to putting a check mark next to the following items: -90-day Assessments (yes or no)	01620		

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01620	Continued From page 20 -Face to Face / In Person (yes or no) -Service Plan Reviewed (yes or no) -Abuse Prevention Plan Reviewed (yes or no) -Side Rail Use reviewed (yes or no) RN-E also stated they did an admission assessment and service plan upon admission for R3. They stated they did the last page of the admission assessment for R3's 14-day assessment, and they put a check mark where it said 14-day assessment. On July 2, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-G stated they were not sure how often they were supposed to complete the RN assessments. CNS-G stated they were unsure of the required content to include from the uniform assessment tool. CNS-G also stated they started working for the licensee recently and had not yet been to the facility. The licensee's 6.01 Assessments, Review and Monitoring policy read, "1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. 2. 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. 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of assisted living services. Ongoing resident reassessment and monitoring must be	01620		

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01620	Continued From page 21 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. 4. For residents only receiving assisted living assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5) as listed here: o assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing o providing standby assistance o providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication o providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises o preparing modified diets ordered by a licensed health professional a. the individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person (unless see #2), be in writing dated and signed by the registered nurse who conducted the individualized review. b. the facility will complete an individualized initial review of the resident's needs and preferences. c. The initial review must be completed within 30 calendar days of the start of assisted living services d. 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. "	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for four of four residents (R1, R2, R4 and R5) with hospital bed rails. This resulted in an immediate correction order on July 2, 2024. 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: R1 R1's diagnoses included spinocerebellar ataxia; hypertension; osteoporosis, dysphagia, G Tube	02310		

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02310	Continued From page 23 feeding; spasticity; cerebral palsy; epilepsy, hypercalcemia; paraplegia; femoral neck fracture. R1's Service Plan dated April 1, 2024, indicated R1 received services for bathing, feeding, grooming, medication administration, oral hygiene, toileting, and transferring. R1's record included the following documents: -The Benefits and Risks of Bed Side Rails signed on January 13, 2021; and -Medical Necessity screening For Use of Bed Side Rails completed on September 30, 2021, and September 30, 2022. R1's record lacked the following: -bed rail assessments which were to be completed every 90 days after the initial assessment and with change of condition; and -initial and ongoing bedrail assessment with entrapment zone measurement. R2 R2's diagnoses included severe developmental disability, cerebral palsy, spastic quadriplegia, hydrocephalus with shunt, legally blind (optic atrophy) history of seizures, mild kyphoscoliosis, depression. R2's Service Plan dated July 15, 2023, indicated R2 received services for, bathing, dining, grooming, medication administration, toileting, oral hygiene and transferring. R2's record included the following documents: -Medical Necessity screening For Use of Bed Side Rails signed on March 20, 2023, consenting to the bedrail use. -Medical Necessity screening For Use of Bed Side Rails completed on September 30, 2021,	02310		

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GENERATIONS HOME CARE INC	2616 1ST STREET NORTH WAITE PARK, MN 56387

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02310	Continued From page 24 and September 15, 2022. R2's record lacked the following: -bed rail assessments which were to be completed every 90 days after the initial assessment and with change of condition; and -initial and ongoing bedrail assessment with entrapment zone measurement. R4 R4's diagnoses included subarachnoid hemorrhage, hypertension, insomnia, hypothyroidism, seizure disorder, depression, right Hemiparesis, cerebral aneurysm, cognitive decline, cholecystectomy. R4's Service Plan dated July 15, 2023, indicated R4 received services for, bathing, dining, grooming, medication administration, toileting, oral hygiene, stand by assist and transferring. R4's record included the following documents: -Medical Necessity screening For Use of Bed Side Rails signed on March 31, 2023, consenting to the bedrail use. -Medical Necessity screening For Use of Bed Side Rails completed on August 2, 2019, and April 14, 2021. R4's record lacked the following: -bed rail assessments which were to be completed every 90 days after the initial assessment and with change of condition; and -initial and ongoing bedrail assessment with entrapment zone measurement. R5 R5's diagnoses included severe developmental disability, cerebral palsy, seizure disorder, legally blind, right hemiplegic contractures.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33364	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	2616 1ST STREET NORTH 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
02310	Continued From page 25 R5's Service Plan dated September 8, 2023, indicated R5 received services for, bathing, dining, grooming, medication administration, toileting, oral hygiene, and transferring. R5's record included the following documents: -Medical Necessity screening For Use of Bed Side Rails signed by RN -E on March 20, 2023, but not signed by R5 or R5's legal guardian consenting to the bedrail use. -Medical Necessity screening For Use of Bed Side Rails completed on September 30, 2021. R5's record lacked the following: -resident consent for the bedrail use -bed rail assessments which were to be completed every 90 days after the initial assessment and with change of condition; and -initial and ongoing bedrail assessment with entrapment zone measurement. On July 1, at approximately 1:45p.m., registered nurse (RN)-E stated they did use a check list indicating a side rail use was reviewed. RN-E stated they did not do bedrail assessment or entrapment zone measurements every 90days. They just put a check mark next to the side rail use as reviewed on the checklist every 90 days. On July 2, 2024, at approximately 11:45 a.m., the surveyor observed R1, R2, R4 and R5's hospital bed which had bilateral half upper side rails. The surveyor wiggled and pulled on all bed rails which were firmly attached to the bed. On July 2, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS-G) stated they are not sure how often the bedrail assessment was supposed to be done. CNS-G also stated they	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33364	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 were not aware of the requirement to measure the entrapment zones every 90 days. Medical Necessity screening For Use of Bed Side Rails the licensee utilized for bedrail assessments read, "RN screening for bed side rail use will be conducted every six months and when there is any change in bed equipment." The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's Hospital Bed Side Rails Policy	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33364	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 27 dated March 6, 2023, read, "1. If the resident expresses the desire to use a device or a device is in use/recommended, a nurse will complete a device assessment at the time of move in, every 90 days, upon hospital return, change in condition, and / or upon discovery of a side rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines. b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident's record to include: a. Results of the assessment. b. Discussion with resident/responsible party regarding risks and benefits. c. A Guide to Bed Safety procedure given to resident / representative. d. Manufacturer guidelines will be available upon request. 5. Staff will inspect bed devices daily and be educated to report to a licensed nurse immediately if the device is found to be loose or malfunctioning. 6. The use of physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Licensed Nurse, or Housing Director will be notified immediately." TIME PERIOD FOR CORRECTION: Immediate On July 3, 2024, the immediacy of correction order 2310 was removed, however	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 28 non-compliance remained, and the scope and level remained unchanged.	02310		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *07/01/24*
Time: 11:00:44
Report: 1041241147

Food and Beverage Establishment Inspection Report

Location:
Generations Home Care Inc
2616 1st Street North
Waite Park, MN56387
Stearns County, 73

Establishment Info:
ID #: 0038615
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.

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.

THE DISHWASHER MEASURED 0PPM CHLORINE AT TIME OF INSPECTION. REPAIR TECH HAS BEEN CALLED. SANITIZE DISHES IN THE SINK WITH A BLEACH SOLUTION UNTIL DISHWASHER HAS BEEN REPAIRED.

Comply By: 07/01/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

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

DICED HAM IN THE UPRIGHT COOLER WAS NOT DATE MARKED. MARK ALL OPENED PACKAGES OF TCS FOOD WITH THE DATE IT WAS OPENED.

Comply By: 07/02/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

AS STATED ABOVE, POST THE CFPM STATE CERTIFICATE

Comply By: 07/16/24

Type: Full
Date: *07/01/24*
Time: 11:00:44
Report: 1041241147
Generations Home Care Inc

Food and Beverage Establishment Inspection Report

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

REMOVE WOODEN KNIFE BLOCK.

Comply By: 07/16/24

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: WATERMELON CHUNKS
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1041241147 of 07/01/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Linda Heinen
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us