Electronically Delivered

December 31, 2024

Licensee
Gabby Care Homes LLC - Cilla House
1500 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL35601016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	35601	A. BUILDING: _____ B. WING _____	11/22/2024

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 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: SL35601016-0 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six resident(s); all of whom were receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 have a written emergency preparedness (EP) 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	0 680		

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0 680	Continued From page 2 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 lacked evidence of having an emergency disaster preparedness plan that contained the following required content: - communication plan must include all the following names/contact information: residents' physicians. On November 19, 2024, at 10:55 a.m. licensed assisted living director (LALD)-C acknowledged they were missing the documentation of the above-mentioned items in the licensee's EP plan and stated, "We don't have that; it is still a work in progress." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 3 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms and comply with Minnesota Fire Code, Minnesota Rules 7511. 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 the potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, at 1:40 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the tour, the surveyor observed the following:	0 780		

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0 780	Continued From page 4 1. When smoke alarms were tested by CNS-D, all of the required dwelling unit smoke alarms were not actuated in the 1500 building. When smoke alarms were tested by CNS-D, the smoke alarms in bedrooms 4 and 5 were not actuated in the 1502 building. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on November 19, 2024, CNS-D verified the above listed smoke alarm observations. 2. Burnt cigarettes were disposed of on the ground on the exterior of the facility, creating a fire hazard. 3. The path to the egress window was obstructed by furniture and personal items stored in front of the window in occupied resident room 4 in the 1500 building. The improper placement of furniture and personal items could delay exiting in the event of an emergency. 4. An extension cord was plugged into 3 multiplug adapters in the IT closet and an extension cord was used to supply power in occupied resident room 3 in the 1502 building. Improper use of extension cords and multiplug adapters creates a fire hazard. During the facility tour interview on November 19, 2024, CNS-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 5 (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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 the potential to affect a large portion or all of the residents). The findings include: On November 19, 2024, at 1:40 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the tour, the surveyor observed the following: 1. The egress window pane was cracked in occupied resident room 4 in the 1500 building. 2. There were gaps in the dining room floor in the 1502 building.	0 800		

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0 800	Continued From page 6 3. Base trim was missing at the floor/wall junction and there was a hole in the wall behind the door in unoccupied bedroom 1 in the 1502 building. 4. There were gaps between the tub/shower combination and the floor in the resident bathroom on the main floor in the 1502 building. 5. An electrical outlet box was loose on the exterior of the facility. 6. A door knob was not installed on the laundry room door. During the facility tour interview on November 19, 2024, CNS-D verified the above listed physical environment observations. 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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 7 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required 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 November 19, 2024, registered nurse/licensed assisted living director (RN/LALD)-C and clinical nurse supervisor (CNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 8 evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP floor plan failed to include the number of resident sleeping rooms. On November 19, 2024, at 1:40 p.m., the surveyor toured the facility with CNS-D. During the tour, the surveyor observed numbers were posted on the resident sleeping room doors. Record review of the available documentation indicated the licensee failed to include sleeping room number labels on the posted FSEP floor plans dated October 26, 2024. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview on November 19, 2024, at 3:15 p.m., RN/LALD-C and CNS-D verified the FSEP floor plan required revision. TRAINING Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. The surveyor requested documentation to support resident training had been completed. On November 21, 2024, at 8:32 a.m., RN/LALD-C emailed that residents were trained on proper actions to take in the event of a fire and these records would be emailed to the surveyor that day. No resident training records were provided for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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02290	Continued From page 9	02290		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee established written house rules and regulations that used language which limited the rights for residents. This had the potential to affect all residents residing within 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, at 11:30 a.m., while touring the facility, the surveyor observed the licensee's Resident Guidelines form dated August 1, 2021. The Resident Guidelines form indicated, "There are no street drugs, alcohol, or over the counter medications allowed on the property or in your room. Any violation of this rule will result in termination of your housing and your services contract and notification of the appropriate law enforcement agencies."	02290		

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02290	Continued From page 10 On November 19, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-D stated, "We don't know how to word the no alcohol exactly because we want to keep that in there because it is out of safety concerns, but also want to make sure we are doing things right." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Minnesota Department of Health

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

Type: Full
Date: *11/19/24*
Time: 14:30:00
Report: 8087241259

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: 11 Degrees Fahrenheit - Location: 1500 - FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: 1500 - REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: 1500 - REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MAYO
Temperature: 38 Degrees Fahrenheit - Location: 1500 - REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: -6 Degrees Fahrenheit - Location: 1502 - FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 35 Degrees Fahrenheit - Location: 1502 - REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: 1502 - REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MAYO
Temperature: 35 Degrees Fahrenheit - Location: 1502 - REFRIGERATOR
Violation Issued: No

Type: Full
Date: *11/19/24*
Time: 14:30:00
Report: 8087241259
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 TESA BROWN.

1502 - FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. 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.

1500 - FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. 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.

1502 - LG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

1500 - LG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

1502 - HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 123 DEGREES.

1500 - HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

1502 - DESIGNATED HAND WASHING SINK IN THE KITCHEN LOCATED ON THE LEFT SIDE OF THE 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

1500 - DESIGNATED HAND WASHING SINK IN THE KITCHEN LOCATED ON THE RIGHT SIDE OF THE 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR TESA BROWN.

Type: Full
Date: *11/19/24*
Time: 14:30:00
Report: 8087241259
Gabby Care Homes Llc - Cilla H

Food and Beverage Establishment Inspection Report

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 8087241259 of 11/19/24.

Certified Food Protection Manager: JOY M. MARABU

Certification Number: FM110188 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
MARY ONDIEKI
HOUSE ASSISTANT

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