Electronically Delivered

December 17, 2024

Licensee
EvyGabs Healthcare Systems LLC
339 Pendryn Hill Curve
Woodbury, MN 55125

RE: Project Number(s) SL40349015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 7, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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.

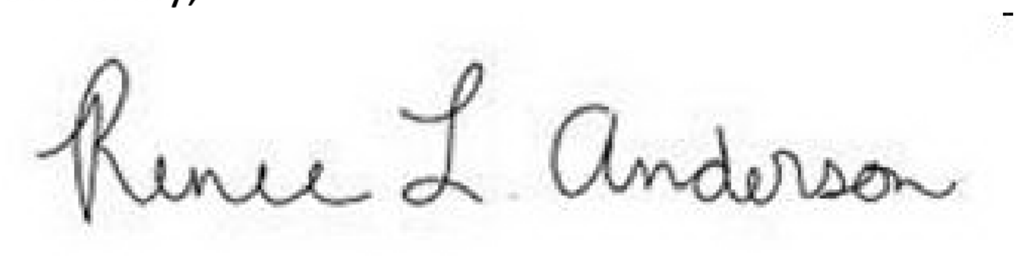
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	40349	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVYGABS HEALTHCARE SYSTEMS LLC	339 PENDRYN HILL CURVE WOODBURY, MN 55125

(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: SL40349015-0 On November 5, 2024, through November 7, 2024, 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 was one resident; one receiving services under the provider's Provisional Assisted Living Facility 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 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 November 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	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	0 660		

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0 660	Continued From page 2 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completing a facility TB risk assessment. 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 facility TB risk assessment indicated it had been completed November 5, 2024, during the time of survey. On November 5, 2024, at 2:45 p.m., licensed assisted living director/registered nurse	0 660		

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0 660	Continued From page 3 (LALD/RN)-B stated she had not completed a TB risk assessment prior to the survey date. LALD/RN-B further stated the licensee only recently started providing care to residents, so she did not think one need to be completed yet. The licensee's undated 8.16 Tuberculosis Screening policy indicated the facility would maintain a current community TB risk assessment and the assessment would be updated annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. 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: (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;	0 680		

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0 680	Continued From page 4 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - a date in which the EPP was established; - a written risk assessment utilizing an all-hazards approach; -EP policies and procedures based on the EP,	0 680		

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0 680	Continued From page 5 risk assessment & communication plan; - policies and procedures related to subsistence needs for staff and patients; -a written communication plan that was reviewed. On November 6, 2024, at 11:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the licensees emergency preparedness plan was not complete, and a hazard risk assessment had not been done. The licensee's undated 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy, indicated the EPP would include all the required elements of Appendix Z and would be based on the plans hazard risk assessment. 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; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 6 (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 throughout the facility and failed to maintain the facility in compliance with Minnesota State Fire Code, MN Rules Chapter 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 a facility tour with chief executive officer (CEO)-A, on November 5, 2024, from 1:00 p.m. to 3:00 p.m., it was observed that a battery smoke alarm in the basement common area outside of the sleeping rooms was not interconnected with hard-wired alarms throughout the facility.	0 780		

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0 780	Continued From page 7 The designated smoking area was not provided with fire-rated ashtrays. The resident was using an open glass ashtray filled with used cigarettes. The surveyor explained to CEO-A that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a fire hazard if cigarettes were not completely extinguished before discarding them. It was observed that the required hardwired smoke alarm on the main floor at the top of the basement stairs was over 10 years old. Smoke alarms are required to be replaced within 10 years of manufacture date while maintaining the same power supply according to current Minnesota Fire Code. These deficient conditions were visually verified by CEO-A accompanying on the tour. On November 5, 2024, at 2:30 p.m., CEO-A stated they had installed two new hard-wired smoke alarms in the basement resident rooms, but they did not know why the common area were battery powered. CEO-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 810		

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0 810	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 9 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 a facility tour with chief executive officer (CEO)-A, on November 5, 2024, from 1:00 p.m. to 3:00 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants' accessibility and did not include a floor plan. On November 5, 2024, CEO-A 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 "Fire Policy", dated 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. 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 pull stations.	0 810		

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0 810	Continued From page 10 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On November 5, 2024, at 2:30 p.m., CEO-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. CEO-A was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. On November 5, 2024, at 2:30 p.m., CEO-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS:	0 810		

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0 810	Continued From page 11 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Licensee lacked any documentation of drills since obtaining license. No other documentation was provided. On November 5, 2024, at 2:30 p.m., CEO-A stated they only had one resident for a few months and did not know drills were still to be required to be conducted by staff. Education was given, that drills are still required for staff in accordance with statue requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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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
01370	Continued From page 12 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed in all required areas for one of one unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C had a start date of September 18, 2024, and provided direct care services for residents of	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40349	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVYGABS HEALTHCARE SYSTEMS LLC	339 PENDRYN HILL CURVE WOODBURY, MN 55125

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01370	Continued From page 13 the facility. On November 6, 2024, at 8:20 a.m., ULP-C was observed administering medications to the licensee resident. ULP-C's employee record lacked documentation to indicate ULP-C completed training on: - understanding appropriate boundaries between staff and residents and the resident's family. On November 6, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated ULP-C had not completed all required training, and training on boundaries was missed. The licensee's undated 5.02 Competency Training Evaluations policy indicated training and competency evaluations of ULPs would be conducted by the RN and would include understanding appropriate boundaries between staff and residents and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (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	01530		

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01530	Continued From page 14 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 ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training, in the required time frame. 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:	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40349	A. BUILDING: _____ B. WING _____	11/07/2024

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01530	Continued From page 15 ULP-C had a start date of September 18, 2024, and provided direct care services for residents of the facility. ULP-C's record contained documentation the employee completed seven hours of dementia related training, short of the required 8 hours initial training. On November 6, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the above required training had not been completed. LALD/RN-B further stated she thought she needed to assign eight courses related to dementia care and was not aware there was an hour requirement. The licensee's 5.03 Dementia Training policy, dated June 1, 2024, indicated direct-care staff were required to complete eight hours of initial training on dementia care within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee	01880		

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01880	Continued From page 16 failed to ensure medications were stored according to manufacturer's instructions. 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 the potential to affect a large portion or all of the residents). The findings include: On November 5, 2024, at 11:45 a.m., the surveyor observed the contents of the licensee's medication refrigerator with licensed assisted living director/registered nurse (LALD/RN)-B. The refrigerator contained 4 injector pens of insulin aspart (fast-acting insulin used to lower blood sugar) and two Lantus insulin injector pens (long-acting insulin used to lower blood sugar). The refrigerator lacked a thermometer to record temperature to ensure the insulin was stored per manufacturer directions. LALD/RN-B stated there should be a thermometer in the refrigerator. LALD/RN-B further stated she had a thermometer for the refrigerator at the office, but she had forgotten it. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be refrigerated at 36-46 degrees Fahrenheit (F) when not in use. The manufacturer's prescribing information for the use of Lantus insulin pens, revised June 2023, indicated unopened medication should be	01880		

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01880	Continued From page 17 refrigerated at 36-46 degrees F. The licensee's 7.11 Medication Storage policy, dated June 1, 2024, indicated medications requiring refrigeration would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	03090		

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03090	Continued From page 18 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 5, 2024, at 10:00 a.m., upon entrance to the facility, the surveyor observed the licensee lacked an electric monitoring notice with the required statutory language. On November 6, 2024, at 11:25 a.m., chief executive officer (CEO)-A stated there was not an electronic monitoring notice posted at the front entrance. CEO-A further stated he was not aware of the requirement and would get a sign posted as soon as possible. The licensee's 2.15 Electronic Monitoring policy, dated June 1, 2021, indicated the licensee would post a sign at each facility entrance accessible to visitors that stated, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/05/24*
Time: 02:49:44
Report: 1036241239

Food and Beverage Establishment Inspection Report

Location:
EVYGABS HEALTHCARE SYSTEMS
339 PENDRYN HILL CURVE
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0043797
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. ILLNESS LOG WAS PROVIDED VIA EMAIL TO MDH THE FOLLOWING DAY AFTER INSPECTION. ISSUE CORRECTED ON SITE.

Comply By: 11/26/24

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

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

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

OBSERVED EGGS STORED OVER RTE FOOD IN THE FRIDGE. EGGS WERE MOVED TO BOTTOM SHELF. ISSUE CORRECTED ON SITE.

Corrected on Site

3-500C Microbial Control: date marking

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

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

OBSERVED SOME OPENED PACKAGES/CONTAINERS (SHREDDED CHEESE, MARINARA SAUCE, CREAM CHEESE) IN THE FRIDGE WITH NO DATE LABEL. EXPLAINED THE NEED

TO ESTABLISH A CONSISTENT DATE LABELING SYSTEM FOR ANY OPENED TCS FOODS.
Comply By: 11/26/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER WAS AVAILABLE AT ESTABLISHMENT. EXPLAINED IMPORTANCE OF HAVING A FOOD TEMPERATURE MEASURING DEVICE ON SITE. PROVIDE AND MAINTAIN.
Comply By: 11/26/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE ON HAND FOR MEASURING THE UTENSIL SURFACE TEMP OF DISH MACHINE. MDH LEFT A FEW THERMOLABEL TEST STRIPS FOR ESTABLISHMENT UNTIL SOME CAN BE OBTAINED.
Comply By: 11/26/24

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM EMPLOYED AT ESTABLISHMENT. EVELINE MBA TOOK A FOOD SAFETY CLASS ON 11/9/21 BUT NEVER REGISTERED WITH THE MDH WITHIN 6 MONTHS OF OBTAINING CERTIFICATE. INSTRUCTIONS FOR OBTAINING CFPM SENT TO ESTABLISHMENT ALONG WITH REPORT.
Comply By: 11/26/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 1 Degrees Fahrenheit - Location: SAMSUNG FREEZER
Violation Issued: No

Type: Full
Date: *11/05/24*
Time: 02:49:44
Report: 1036241239
EVYGABS HEALTHCARE SYSTEMS

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TAMMY CARLSON. INSPECTION CONDUCTED IN PRESENCE OF EVELINE MBA, DIRECTOR, AND GABRIEL MBA, THE PERSON IN CHARGE. AT TIME OF
INSPECTION, ESTABLISHMENT HAD ONE RESIDENT.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.
**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241239 of 11/05/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
GABRIEL MBA
PERSON IN CHARGE

Signed:_____
Jeff Johanson