Electronically Delivered

April 11, 2023

Licensee
Guardian Care Homes Inc
7221 First Avenue South
Richfield, MN 55423

RE: Project Number(s) SL38523015

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 evaluation on March 27, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also

may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

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

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

Sincerely,

Jessica Sellner, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 320-223-7370 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38523	A. BUILDING: _____ B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE HOMES INC	7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38523015 On March 27, 2023, the Minnesota Department of Health conducted a provisional survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident receiving services under the provider's Assisted Living license.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and	0 470		

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0 470	Continued From page 1 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed for determining its staffing level as required and post a daily staffing schedule in a central location. This had the potential to affect all residents receiving services from the licensee. 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). Findings include: The licensee failed to develop and implement a	0 470		

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0 470	Continued From page 2 staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On March 27, 2023, at 9:15 a.m., licensed assisted living director (LALD)-A stated the facility was staffed according to need and resident census. LALD-A stated the facility did not have a written plan in place to address staffing and post a daily staff schedule because the residents knew everyone who worked there. The licensee's undated policy titled Minimum Assisted Living Facility Requirements indicated Guardian Care Homes would develop a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
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,	0 480		

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0 480	Continued From page 3 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all #1 residents residing at 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated March 27, 2023. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 485		

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0 485	Continued From page 4 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee also failed to post a menu a week in advance and made available to residents. This had the potential to affect all residents receiving services from the licensee. 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). Findings include: On March 27, 2023, at 11:00 a.m., the surveyor observed no weekly menu posted in a central area. The surveyor requested a copy of the week's menu. A menu was not provided, so the surveyor was unable to assess the nutritional qualities of the meals provided by the facility. On March 27, 2023, at 11:00 a.m., licensed	0 485		

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0 485	Continued From page 5 assisted living director (LALD)-A stated the facility did not utilize a weekly menu since the residents usually order out their food. The licensee's undated policy titled Minimum Assisted Living Facility Requirements indicated Guardian Care Homes addressed providing meals but did not address the development of a weekly menu. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control, consistent with current guidelines from the Centers for	0 510		

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0 510	Continued From page 6 Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. This had the potential to affect all residents receiving services from the licensee. 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). Findings include: On March 27, 2023, at 10:15 a.m., surveyors observed the staff restroom. Signs were posted instructing staff to wash their hands however, there was no hand soap, hand sanitizer, or towels available for staff. There was one bottle of hand soap located at the kitchen sink, where resident dishes were washed, but no towels available to dry hands. On March 27, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A was observed administering oral medication to resident (R)-1. LALD-A poured the tablets into her bare hand, and then transferred the tablets into a medication cup to administer them to R1. LALD-A was not observed washing her hands either before or after the interaction. On March 27, 2023, at 2:45 p.m., LALD-A stated she should have placed the medication directly into the medication cup, rather than her hand, before administering the tablets to R1.	0 510		

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0 510	Continued From page 7 The licensee's undated policy titled Infection Control/CDC Standards indicated Guardian Care Homes will observe the recommended precautions as identified by the CDC. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) Days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activity appropriate to the size of the facility and relevant to the type of services provided and failed to maintain documentation on quality management activities. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 8 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). Findings include: During the entrance conference interview on March 27, 2023, at 9:25 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B verbalized familiarity with quality management requirements in the assisted living statutes. On March 27, 2023, at 10:10 a.m., surveyors requested documented evidence of quality management activities for the facility. Despite repeated requests for this information, surveyors never received this documentation. The licensee's undated policy titled Quality Management Program indicated documentation of quality management activities will be provided at the time of survey as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 9 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 10 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) document for one of one residents (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: R1 medical record indicated R1 was admitted to the facility on September 30, 2022. R1's diagnoses included right-sided weakness, bowel incontinence, depression, anxiety, and schizophrenia. R1's service plan, dated October 4, 2022, indicated R1 received assistance with dressing, bathing, transfers, laundry, housekeeping, and medication management. R1's chart lacked a UDALSA. On March 27, 2023, at 2:45 p.m., registered nurse (RN)-B verbalized familiarity with the UDALSA but had no explanation why there was no UDALSA in R1's chart.	0 730		

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0 730	Continued From page 11 The licensee's undated Resident Records policy did not address the UDALSA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current 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	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38523	A. BUILDING: _____ B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE HOMES INC	7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423

(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
0 790	Continued From page 12 a large portion or all of the residents). Findings include: On March 27, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. It was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. During the tour, LALD-A stated that the fire extinguisher was certificated in 2021 when it was purchased but did not update the certification since. This deficient condition was verified by LALD-A accompanying on the facility tour.	0 790		
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	0 800		

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0 800	Continued From page 13 residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 March 27, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the following items: It was observed that the furnace was broken, and the facility did not have heat. During the interview, LALD-A stated that the repair had been scheduled and the repair would be completed on the same day. On March 29, 2023, at approximately 1:00 p.m., survey staff made a follow-up call to the facility, and LALD-A confirmed that the furnace had been repaired and was in working condition. In the main entrance door, it was observed that the glass storm door was missing the glass panel. In the upper-level resident bedroom #2 and #4, it was observed that the window screen was missing. In the lower-level resident bedroom #5, it was observed the following items:	0 800		

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0 800	Continued From page 14 - It was observed that the egress window was obstructed by a well cover that was bolted down and covered with snow. - It was observed that the egress window well was deeper than 44 inches but did not have a permanently affixed ladder or steps installed. - It was observed that the bedroom door was broken with holes. In the lower-level bathroom, it was observed the following items: - It was observed that the bedroom entry threshold step did not have a finish installed and had exposed concrete. - It was observed that the shower booth had considerable black stains. - It was observed that the toilet and tile floor had considerable brown stains. - It was observed that the light fixture over the vanity was broken. In the lower-level laundry area, it was observed that the washer was broken. During the interview, LALD-A stated that the washer was broken on the day of the survey and needed to be replaced. The lower-level furnace was located in an open space next to bedroom #5 and was not secured from resident access. LALD-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 15 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of	0 810		

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0 810	Continued From page 16 assisting in their own evacuation and failed to conduct required evacuation drills. This 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: An interview and record review of the available documentation were conducted on March 27, 2023, at approximately 1:00 p.m., with the Licensed Assisted Living Director (LALD)-A and Registered Nurse (RN)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, RN-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available document indicated that employees did not receive trainings on the fire safety and evacuation plans upon hiring and at least twice per years thereafter as required by statute. During interview, RN-B stated that all staff receive emergency and disaster training in orientation and verified that there were no further	0 810		

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0 810	Continued From page 17 documented training for the staffs on the fire safety and evacuation plan as required by statute. Record review of the available documentation indicated that evacuation drills for employees had not been performed every other month as required. During interview, RN-B stated that evacuation drills had not been performed for the employees at the time of survey. A policy was requested on evacuation drills, but one was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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01730	Continued From page 18 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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). Findings include:	01730		

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01730	Continued From page 19 R1's medical record indicated R1 was admitted to the facility on September 30, 2022. R1's diagnoses included right-sided weakness, bowel incontinence, depression, anxiety, and schizophrenia. R1's service plan, dated October 4, 2022, indicated R1 received assistance with dressing, bathing, transfers, laundry, housekeeping, and medication management. R1's chart lacked a medication management plan that included the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions, -documentation of specific resident instructions relating to the administration of medications, -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, -identification of medication management tasks that may be delegated to unlicensed personnel, -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, -any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On March 27, 2023, at 2:00 p.m., a surveyor observed licensed assisted living director (LALD)-A administering medications to R1.	01730		

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01730	Continued From page 20 On March 27, 2023, at 2:45 p.m., registered nurse (RN)-B stated R1's record would be updated in accordance with assisted living statutes. The licensee's undated policy titled Medication Management Program indicated the licensee would develop and maintain a current individualized medication management record for each resident with all required components in accordance with assisted living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02310 SS=F	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 standards, medical or nursing standards for one of one resident (R1) who received medication management services with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	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 21 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). Findings include: R1's medical record indicated R1 was admitted to the facility on September 30, 2022. R1's diagnoses included right-sided weakness, bowel incontinence, depression, anxiety, and schizophrenia. R1's service plan, dated October 4, 2022, indicated R1 received assistance with dressing, bathing, transfers, laundry, housekeeping, and medication management. Licensed assisted living director (LALD)-A personnel filed indicated LALD-A was hired on September 15, 2022, and received training as an unlicensed personnel to provide assisted living services to residents of the facility. On March 27, 2023, at 2:00 p.m., LALD-A was observed administering medications to R1. When the medication administration record (MAR) was reviewed, R1's medications had been signed off from March 1 2023, through March 31, 2023. When interviewed on March 27, 2023, at 2:00 p.m., LALD-A stated she signed medications off at the start of each month because she was busy. The licensee's undated policy titled Medication Management Program did not address documenting administration of medications after the medications are administered.	02310		

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02310	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
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 a required notice was posted at the main entryway of the facility to display statutory language disclosing electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). Findings include: On March 27, 2023, at 9:15 a.m., observation was made of the main entrance at the facility.	03090		

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03090	Continued From page 23 There was no signage notifying visitors o thef licensee's electronic monitoring. On March 27, 2023, at 2:45 p.m., licensed assisted living director (LALD)-A stated she was unaware of the statutory requirement for posting an electronic monitoring notice. The licensee lacked an electronic monitoring policy in accordance with Assisted Living Licensure requirements, effective August 1, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *03/27/23*
Time: 11:42:17
Report: 1018231055

Food and Beverage Establishment Inspection Report

Location:
Guardian Care Homes Inc
7221 First Avenue S
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0041114
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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 at the specific request of the regulatory authority.

ESTABLISHMENT IS NOT CURRENTLY KEEPING AN ILLNESS LOG FOR EMPLOYEES. COMPLY WITH RULE. ILLNESS LOG SENT TO MANAGER.

Comply By: 03/29/23

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.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. COMPLY WITH RULE.

Comply By: 03/27/23

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT CURRENTLY HAVE A CERTIFIED FOOD PROTECTION MANAGER. APPLICATION AND INFORMATION SENT TO MANAGER.

Comply By: 06/01/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

MICROWAVE, STOVE AND REFRIGERATOR WERE OBSERVED WITH HEAVY DEBRIS BUILD-UP. DISCUSSED WITH THE MANAGER TO CLEAN THESE ITEMS.

Comply By: 03/29/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CABINET ABOVE REFRIGERATOR IS FALLING OFF OF THE WALL. DISCUSSED WITH MANAGER TO HAVE THE CABINET REPAIRED.

OBSERVED TWO CABINET DOORS FALLING OFF HINGES. COMPLY WITH RULE.

Comply By: 04/05/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

OBSERVED EVIDENCE OF MICE IN BOTTOM CABINET NEAR THE REFRIGERATOR. DISCUSSED PEST CONTROL WITH MANAGER.

Comply By: 03/27/23

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	4

INSPECTION CONDUCTED WITH MAERIN RENEE (MDH) PRESENT

ESTABLISHMENT DOES ONLY SAME DAY SERVICE OF FOODS.

PHYSICAL FACILITIES OBSERVED IN GOOD CONDITION EXCEPT FOR ITEMS NOTED ON REPORT.

DISHWASHER OBSERVED WITH SANITIZE FUNCTION.

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 1018231055 of 03/27/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
MUNIRA S MOHAMED
MANAGER

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us