Electronically delivered

April 12, 2022

Administrator
Generations Home Care, Inc.
119 3rd Avenue Southeast
Saint Joseph, MN 56374

RE: Project Number(s) SL35678015

Dear Administrator:

On April 6, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 5, 2021. The follow-up evaluation determined your agency had corrected all of the state licensing orders issued pursuant to the November 5, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 5, 2021, found not corrected at the time of the April 6, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 6, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35678	A. BUILDING: _____ B. WING _____	R 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL35678015 On April 6, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 5, 2021, and a revisit survey completed on February 7, 2022. At the time of the survey, there were five residents, all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on April 6, 2022, 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), 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	{0 340}		

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{0 340}	Continued From page 2 of the residents). The findings include: During the revisit survey on April 6, 2022, the surveyor reviewed the licensee's policies and procedures, resident records, employee records and conducted interviews with licensed assisted living director (LALD)-A. The licensee lacked evidence to indicate the orders issued on November 5, 2021, were corrected. No further information was provided.	{0 340}		
{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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further information required.	{0 480}		

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{0 780}	Continued From page 3	{0 780}		
{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; (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: No further action required.	{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 plans shall include but are not limited to: (1) location and number of resident sleeping	{0 810}		

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{0 810}	Continued From page 4 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: No further action required.	{0 810}		
{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	{01530}		

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{01530}	Continued From page 5 least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-J) received the required amount of dementia care training, in the required time frame, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	{01530}		

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{01530}	Continued From page 6 situation has occurred only occasionally). The findings include: The licensee provided services under an Assisted Living license. ULP-J started employment on May 25, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-J's employee record contained evidence the employee received 3.75 hours of dementia care training, not the required 8 hours of training. On April 6, 2022, at approximately 9:50 a.m., licensed assisted living director (LALD)-A verified ULP-J's training was short of the required 8 hours. The licensee's Dementia Training policy dated August 1, 2021, noted direct-care staff would complete 8 hours initial training within 160 working hours, and all staff would complete two hours additional training for each 12 months of work thereafter. No further information was provided.	{01530}		
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	{01650}		

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{01650}	Continued From page 7 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R3 and R4) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01650}		

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{01650}	Continued From page 8 The findings include: R3 and R4's service plans lacked the following: - the schedule of monitoring assessments of the resident; and - a contingency plan that included: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3's Service Plan dated March 31, 2022, indicated R3 received assistance with activities of daily living and medication administration. The plan noted R3 had a health care directive and noted the type as a Physician Orders for Life Sustaining Treatment (POLST), but lacked the declarations made in the POLST. In addition, R3's plan noted the monitoring reassessment schedule to include initial upon admission, within 14 days, within and not to exceed 90 days and with change in condition. However, the plan failed to mention the assisted living facility would conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. R4 R4's Service Plan dated March 24, 2022, indicated R4 received assistance with activities of daily living and medication administration. The plan noted R4 did not have a health care directive but lacked the resident's directives. In addition,	{01650}		

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{01650}	Continued From page 9 R4's plan noted the monitoring reassessment schedule to include initial upon admission, within 14 days, within and not to exceed 90 days and with change in condition. However, the plan failed to mention the assisted living facility would conduct a nursing assessment by a registered ruse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. On April 6, 2022, at approximately 9:50 a.m., licensed assisted living director (LALD)-A confirmed the resident service plans for R3 and R4 lacked the above required content. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a description of the services that would be provided, the schedule for the next planned assessment or monitoring and a contingency plan that included how the facility would support documented resident health care directive decisions, if any, including circumstances when emergency medical services were not to be summoned. No further information was provided.	{01650}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 25, 2022

Administrator
Generations Home Care, Inc.
119 3rd Avenue Southeast
Saint Joseph, MN 56374

RE: Project Number(s) SL35678015

Dear Administrator:

On January 18, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 5, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 5, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 5, 2021, found not corrected at the time of the January 18, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 18, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 18, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 = $500.00

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must

document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Case DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results

of this visit with the President of your facility's Governing Body.

Sincerely,

Case DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

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GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL35678015 On February 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 5, 2021. At the time of the survey, there were six residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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	35678	A. BUILDING: _____ B. WING _____	R 01/18/2022

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on November 5, 2021, 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), 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	0 340		

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0 340	Continued From page 2 of the residents). The findings include: During the revisit survey on February 7, 2022, the surveyor reviewed the licensee's policies and procedures, resident records, employee records and conducted interviews with licensed assisted living director (LALD)-A and registered (RN)-B. The licensee lacked evidence to indicate the orders issued on November 5, 2021, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required	{0 680}		

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{0 680}	Continued From page 4 content. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 7, 2022, at approximately 1:00 p.m., the surveyor reviewed the emergency preparedness plan and Appendix Z with licensed assisted living director (LALD)-A. LALD-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include: - hazard and vulnerability assessment; - at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - policy and procedure to address food, water, medical supplies, pharmaceutical supplies for evacuation and sheltering in place; - policy and procedure to address sewage and waste disposal; - policy and procedure to address safe evacuation; - policy and procedure to address sheltering in place for residents, staff, and volunteers who remain in the facility; - policy and procedure to address a system of medical documentation to preserve resident information, protects confidentiality, and secured/maintained availability of records;	{0 680}		

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{0 680}	Continued From page 5 - policy and procedure to address the use of volunteers; - policy and procedure to address the development of arrangements with other facilities to receive residents in the event of limitations/cessation of operations to maintain the continuity of services with signed agreements and a plan to transport in an evacuation; - policy and procedure to address providing care and treatment at alternate care sites under the 1135 waiver; - a written communication plan to include the required content; and - EP training and testing program. A policy related to emergency preparedness was requested, but not provided. No further information was provided.	{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; (iv) where more than one smoke alarm is required within an individual dwelling unit or	{0 780}		

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{0 780}	Continued From page 6 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: No further action required.	{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 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	{0 810}		

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{0 810}	Continued From page 7 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: No further action required.	{0 810}		
{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 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	{01530}		

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{01530}	Continued From page 8 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 four employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training, in the required time frame 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an assisted living license. ULP-C started employment on January 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's employee record contained evidence the employee had received 6.75 hours training, and not the required 8 hours of training within 160 working hours which occurred on February 22, 2020.	{01530}		

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{01530}	Continued From page 9 On February 7, 2022, at approximately 11:40 a.m., licensed assisted living director (LALD)-A verified ULP-C's training was short of the required 8 hours. The licensee's Dementia Training policy dated August 1, 2021, noted direct-care staff would complete 8 hours initial training within 160 working hours, and all staff would complete two hours additional training for each 12 months of work thereafter. No further information was provided.	{01530}		
{01650} SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	{01650}		

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{01650}	Continued From page 10 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1 and R3) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 and R3's service plans lacked the following: - the schedule of monitoring assessments of the resident; and - a contingency plan that included: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R1 R1's Service Plan dated December 1, 2021, indicated R1 received assistance with medication	{01650}		

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{01650}	Continued From page 11 administration. The plan noted R1 had a health care directive and to see the chart. In addition, the plan noted the monitoring and reassessment schedule to include the following: - initial, within 14 days, within and not to exceed 90 days and with change in condition. R3 R3's Service Plan dated January 17, 2022, indicated R3 received assistance with activities of daily living and medication administration. The plan noted R3 had a health care directive, and to see the chart. In addition, the plan noted the monitoring and reassessment schedule to include the following: - initial, within 14 days, within and not to exceed 90 days and with change in condition. On February 7, 2022, at approximately 11:40 a.m., licensed assisted living director (LALD)-A confirmed the resident service plans for R1 and R3 lacked the above required content. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a description of the services that would be provided, the schedule for the next planned assessment or monitoring and a contingency plan that included how the facility would support documented resident health care directive decisions, if any, including circumstances when emergency medical services were not to be summoned. No further information was provided.	{01650}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication	{01760}		

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{01760}	Continued From page 12 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R1) observed with insulin administration via a prefilled insulin pen, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's insulin was not administered according to the manufacturer's instructions. R1's Service Plan dated October 15, 2021,	{01760}		

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{01760}	Continued From page 13 indicated R1 received assistance with medication administration. R1's prescriber orders dated October 11, 2021, included Basaglar (an injectable medication for diabetes) 28 units daily. On February 7, 2022, at approximately 9:15 a.m., unlicensed personnel (ULP)-C stated she had already administered insulin to R1 for his morning dose but agreed to walk through how she administered the insulin. ULP-C stated she dialed the pen to the prescribed 28 units, placed the needle with the cap on it and administered after removing the cap. ULP-C stated the registered nurse (RN) had not trained her to prime the insulin pen by dialing it to 2 units, expressing the insulin and then dialing to the prescribed amount. On February 7, 2022, at approximately 11:00 a.m., registered nurse (RN)-B stated staff were trained to prime the insulin pen before dialing the prescribed dose. The manufacturer's instruction for the use of the Basaglar insulin pen dated July 2021 instructed to prime the pen before each injection by turning the dose to 2 units, tapping the cartridge holder gently to collect air bubbles at the tope, and pushing the dose knob until it stops and returns to 0. It also indicated not priming the pen prior to each injection may result in too much or too little insulin. The licensee's Insulin policy dated August 1, 2021, instructed staff to prime the insulin pen. No further information was provided.	{01760}		

Electronically Delivered

November 29, 2021

Administrator
Generations Home Care Inc
119 3rd Avenue Southeast
Saint Joseph, MN 56374

RE: Project Number(s) SL35678015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 5, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

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

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

The correction order documentation should include the following:

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: SL35678015 On November 3, 2021, through November 5, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 3, 2021, at approximately 10:05 a.m. licensed assisted living director (LALD) and registered nurse (RN)-B stated they reviewed the regulations in the book.	0 250		

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying	0 250		

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0 250	Continued From page 4 a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659	0 250		

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0 250	Continued From page 5 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on May 19, 2021. The licensee had an Assisted Living license, issued on July 6, 2021. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in sections 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management Refer to licensing order at Statute 144G.42, Subd. 6 and 626.557, Subd. 3. The licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2) with records reviewed. Refer to licensing order at Statute 144G.61, Subd. 2 (a and b). The licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D) with records reviewed. Refer to licensing order at Statute 144G.63,	0 250		

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0 250	Continued From page 6 Subd. 2. The licensee failed to ensure employees providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-B, ULP-C and ULP-D) with records reviewed. Refer to licensing order at Statute 144G.64. The licensee failed to ensure three of three employees (RN-B, ULP-C and ULP-D) received the required amount of dementia care training, in the required time frame. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. In addition, the licensee failed to ensure infection control standards were followed for two of three unlicensed personnel (ULP-C and ULP-D). Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees (ULP-D) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 1. The licensee failed to develop, implement and maintain current written medication management policies and procedures that were developed under the supervision and direction of a RN. In addition, the licensee failed to ensure the security and accountability of	0 250		

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0 250	Continued From page 7 controlled substances being managed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the RN conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for one of one resident (R1) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R1) observed with insulin administration via a prefilled insulin pen, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 2. The licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a RN consistent with current practice standards and guidelines, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided for one of one resident (R1) who had a prescribed treatment or therapy, with records reviewed. Twenty-four (24) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	0 250		

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0 250	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
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 (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	0 470		

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0 470	Continued From page 9 was developed and posted as required, potentially affecting the licensee's current residents, staff and any 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 held an assisted living facility license, was licensed for a bed capacity of six residents, and had a current census of six residents. The licensee failed to develop and implement a 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. The licensee's posted Staffing Plan noted "Willow Springs is a six bed assisted living facility. The client level of cares vary from independent to complete assist. Three clients require assistance	0 470		

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0 470	Continued From page 10 of staff to complete transfers, including use of transfer equipment. Three clients attend outside activities each week." Below this, was noted one staff from 11:00 p.m. to 7:00 a.m., two staff from 7:00 a.m. to 3:00 p.m., one staff from 3:00 p.m. to 11:00 p.m., and one staff from 4:00 p.m. to 10:00 p.m., with a total of 38 hours staff time in a 24 hour period. On November 4, 2021, at approximately 11:05 a.m. registered nurse (RN)-B verified the licensee lacked a staffing plan to include the above required content. A policy was requested, but not provided. 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared 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, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 3, 2021, for the specific Minnesota Food Code deficiencies. 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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	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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0 485	Continued From page 12 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; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed ensure at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables, with records reviewed. This had the potential to affect all current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 failed to ensure the following: - meals with seasonal fresh fruit and vegetables; - resident involvement in menu planning; and - meals according to the recommended dietary	0 485		

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0 485	Continued From page 13 allowances in the United States Department of Agriculture (USDA) guidelines The licensee's menu dated October 31, 2021, through November 6, 2021, lacked consistent meals including half plate fruits and vegetables, one quarter plate protein, and one quarter plate grains. On November 4, 2021, at approximately 12:40 p.m. lunch service was observed to include two large chicken strips, half cup macaroni and cheese, and half cup cooked peas On November 5, 2021, at approximately 9:00 a.m. breakfast service was observed to include a fresh apple and a muffin. On November 5, 2021, at approximately 10:27 a.m. licensed assisted living director (LALD) and registered nurse (RN)- B verified they had discussed the meal and menu requirements the previous week, but had not taken actions to implement them. The licensee's Food Service and Menu Planning policy dated August 1, 2021, noted - food would be served according to the Minnesota Food Code, Minnesota Rules, chapter 4626 - the licensee would provide at least three meals daily with snacks available seven days per week according to the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. In addition, the licensee failed to ensure infection control standards were followed for two of three unlicensed personnel (ULP-C and ULP-D). This had the potential to affect all six (6) 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).	0 510		

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0 510	Continued From page 15 The findings include: Personal Protective Equipment (PPE) On November 3, 2021, at approximately 9:05 a.m. upon entering the facility, licensed assisted living director (LALD) was observed wearing a medical-grade facemask, but no eye protection. During the tour on November 3, 2021, at approximately 9:45 a.m. two residents were observed in the dining room, with licensed practical nurse (LPN)-H, registered nurse (RN)-B, unlicensed personnel (ULP)-C and ULP-D. All staff were observed to be wearing a medical-grade facemask, but no eye protection. On November 3, 2021, at approximately 10:30 a.m. LALD stated she thought the direction had changed and eye protection was no longer required, and stated she would get eye protection for staff. On November 4, 2021, at approximately 7:35 a.m. ULP-C and ULP-D were observed to provide personal cares to R3, wearing a medical-grade facemask but no eye protection. On November 5, 2021, at approximately 8:50 a.m. ULP-C was observed to test R1's blood glucose and administer insulin in the resident's room. ULP-C wore a medical-grade facemask, but no eye protection. Resident Screening On November 4, 2021, at approximately 12:43 p.m. ULP-C stated residents were screened with a temperature two times daily, but verified they were not asked any screening questions related	0 510		

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0 510	Continued From page 16 to COVID-19. RN-B stated the staff observed the residents for any signs or symptoms of COVID-19, such as a cough. The licensee's undated COVID-19 policy noted the resident should get tested when they had one of the symptoms (body temp of 100 or more in the last 24 hours, a new persistent cough, chills, loss of taste or smell, nausea, vomiting, or diarrhea) or two of the symptoms (sore throat, muscle/body aches, headache, runny nose or congestion); however, the policy lacked information on screening the residents for the symptoms of COVID-19. The Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well fitting facemask. MDH COVID-19 Toolkit, dated March 8, 2021, instructed to chart all clinical measurements and symptoms for each resident. Hand Hygiene/Infection Control On November 4, 2021, at approximately 7:35 a.m. ULP-C and ULP-D were observed to provide personal cares to R3. Both staff had gloves on, ULP-C removed R3's brief, ULP-D performed perineal cares, and ULP-D placed a clean brief. At this time, both staff removed their gloves and donned clean gloves, without performing hand hygiene. ULP-C put on R3's pants, while ULP-D returned items to the drawers. ULP-D then exited	0 510		

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0 510	Continued From page 17	0 510		

the room to bring in the hoyer lift and wheelchair, and the staff assisted R3 to the wheelchair. Once R3 was seated in the wheelchair, ULP-C removed the shirt, placed deodorant, and a new shirt on R3, and R3 was buckled in the chair with a seatbelt. At this time, both staff removed their gloves, and ULP-C brought R3 to the dining room. At this time, ULP-C was observed to wash her hands in the kitchen sink.

On November 4, 2021, at approximately 8:00 a.m. ULP-C was observed to administer medications to R2 in his room. ULP-C handed R2 the medications after raising the head of bed, handed a glass of juice, lowered the head of bed, removed the gloves, and returned to the medication cart to sign off medications without performing hand hygiene. ULP-C returned to the room to perform a catheter flush on R2. At this time ULP-C donned clean gloves, cleaned R2's mouth guard, placed it in the case, and changed gloves without performing hand hygiene. ULP-C then brought the items necessary to perform the catheter flush, donned gloves, wiped the plunger with an alcohol wipe, removed the night bag and cleaned the port with an alcohol wipe. At this time, ULP-C opened a plastic disposable container which contained a liquid she stated was sodium chloride, and began pulling it into the plunger, and placed it into the catheter, pulled back out, and expressed into a blue plastic bowl on the bed. This was completed three times. The day bag was wiped with an alcohol wipe and placed on R2. The plunger tip was wiped with an alcohol wipe, and the supplies were returned to R2's closet. ULP-C then opened the door with the blue bowl and catheter bag in her hands and went to the bathroom next door. The catheter was emptied into a urinal to measure output and rinsed with vinegar water. At this time, ULP-C

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0 510	Continued From page 18 hung the catheter bag on the rail inside the shower. The bowl was rinsed with vinegar water and returned to R2's closet. At this time, ULP-C removed her gloves and washed her hands in the bathroom sink. On November 4, 2021, at approximately 8:20 a.m. ULP-C stated she should perform hand hygiene after removing her gloves, but stated they could not leave the resident alone when the bed was raised. ULP-C confirmed there was no hand sanitizer available in the resident rooms. On November 4, 2021, at approximately 12:00 p.m. RN-B stated the catheter bags should be stored in the resident rooms, not in the bathroom. At approximately 12:15 p.m., RN-B stated hand hygiene should be done after performing perineal cares and after gloves were removed. In addition, RN-B stated a disposable plastic container should not be utilized for catheter cares. The licensee's Hand Washing and Sanitizing policy dated August 1, 2021, noted handwashing should be completed between tasks and procedures. It also noted hand hygiene should be completed before donning and after doffing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements	0 620		

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0 620	Continued From page 19 for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 3, 2021, at approximately 10:05 a.m. a request was made to the licensed assisted living director (LALD) and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2021. LALD and RN-B stated at this time no reports had been submitted to MAARC in this time period. On November 4, 2021, at approximately 8:00	0 620		

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0 620	Continued From page 20 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R2, in his room. R2's diagnoses included seizures and traumatic brain injury. R2's Service Plan dated June 11, 2021, indicated the resident received services that included, but were not limited to, medication administration, food preparation and catheter cares. A Complaint Form dated August 24, 2021, noted a peer had called former house manager (FHM) and stated R2 had not received supper, indicating staff refused to give it to R2. A note signed by FHM, stated ULP-G had refused to give R2 his supper, because they were waiting for the resident to say how he wanted his waffle cut up. FHM spoke with R2 and ULP-G, and the food was provided. On November 3, 2021, at approximately 11:25 a.m. licensed assisted living director (LALD) stated the supervisor had called the house and corrected staff, who provided food to R2 at that time. LALD stated ULP-G was terminated and did not work again after that date. LALD verified withholding food would be considered a form of abuse, and stated she did not believe the incident had been reported to MAARC. At 11:55 a.m., LALD verified the incident had not been reported to MAARC. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted if the LALD or clinical nurse supervisor confirmed the suspicion of maltreatment they would contact MAARC within 24 hours.	0 620		

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0 620	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees unlicensed personnel (ULP-D) with records reviewed. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 22	0 660		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee's Facility Tuberculosis (TB) Risk Assessment dated August 1, 2021, which lacked the name and address of the facility and added when provided, indicated a low risk level.

ULP-D started employement and began providing assisted living services on September 22, 2021.

On November 4, 2021, at approximately 7:35 a.m. ULP-D was observed to provide personal cares to R3.

ULP-D's employee record contained a TST dated administered on October 4, 2021, read October 6, 2021 (12 days after hire date), with 0 millimeters induration, negative. In addition, the record lacked evidence of a second TST as required.

On November 5, 2021, at approximately 10:45 a.m. licensed assisted living director (LALD) verified ULP-D had not completed the initial TST upon hire, and lacked a second TST as required.

The licensee's Tuberculosis Screening policy dated August 1, 2021, noted new staff would have a blood test or two-step TST, and no staff would be permitted to begin work where the work involved sharing air space with residents until the

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0 660	Continued From page 23 first results were read and documented as negative. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." 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;	0 680		

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0 680	Continued From page 24 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living license, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 3, 2021, at approximately 11:40 a.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was requested.	0 680		

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0 680	Continued From page 25 During the initial tour on November 3, 2021, at approximately 9:45 a.m. the facility's layout included one building with six resident rooms, the kitchen, living room, an office area and dining room located on the main level. The basement was basically empty, and used only storage. On the bulletin board, just inside the front entrance to the right, an Emergency Disaster Plan was displayed, with blank spaces to indicate where the radio and flashlights were located. On November 5, 2021, at approximately 10:00 a.m. licensed assisted living director (LALD) stated the Emergency Disaster Plan posted was taken from documents purchased from a provider group. In addition, LALD confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include: - a written emergency disaster plan that contained 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; -post an emergency disaster plan prominently; -emergency and disaster training to all staff during the initial staff orientation; and -Appendix Z required elements A policy related to emergency preparedness was requested, but not provided. 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	0 780		

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0 780	Continued From page 26 (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; (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 facility failed to have smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate as required by MN Statute 144G.45 subd.2(a)(1). 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	0 780		

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0 780	Continued From page 27 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: On facility tour with the Licensed Assisted Living Director (LALD) between 10:45 a.m. and 11:55 a.m. on November 4, 2021, it was observed that upon testing, the smoke alarms were not interconnected so the actuation of one alarm caused all alarms to operate as required when there is more than one smoke alarm in a dwelling unit. This deficient practice was visually verified by the LALD accompanying on the facility tour. 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 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	0 810		

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0 810	Continued From page 28 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 record review and interview, the licensee failed to provide fire safety and evacuation training at least twice per year after hire to employees as required by MN Statute 144G.45 Subd.2 (c). 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 a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 29 On November 4, 2021, between 10:20 a.m. and 10:45 a.m. an interview and record review was conducted with the Licensed Assisted Living Director (LALD) on fire safety and evacuation training for employees. The licensee did not have any records of fire safety and evacuation training twice a year for each employee after initial hire. An interview conducted with the LALD indicated that the facility policy was to train on fire safety and evacuation at initial hire and annually only, and did not have training twice per year after hire as required by statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the	0 920		

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0 920	Continued From page 30 resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record 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 potential to affect a large portion or all of the residents). The findings include: R1's record lacked a written contract to include: - a disclosure of the category of assisted living facility license held by the facility On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to administer insulin to R1. R1's Service Plan dated October 15, 2021, indicated the resident received assistance with medication administration.	0 920		

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0 920	Continued From page 31 R1's Housing with Services Contract dated September 30, 2021, lacked the above required content. On November 3, 2021, at approximately 3:25 p.m. licensed assisted living director (LALD) confirmed R1's contract lacked the above required content. In addition, LALD stated the same template was utilized for all residents. A policy related to contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the	0 940		

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0 940	Continued From page 32 housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record 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 potential to affect a large portion or all of the residents). The findings include: R1's record lacked a written contract to include: - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;	0 940		

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0 940	Continued From page 33 - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to administer insulin to R1. R1's Service Plan dated October 15, 2021, indicated the resident received assistance medication administration. R1's Housing with Services Contract dated September 30, 2021, lacked the above required content. On November 3, 2021, at approximately 3:25 p.m. licensed assisted living director (LALD) confirmed R1's contract lacked the above required content. In addition, LALD stated the same template was utilized for all residents. A policy related to contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01370 SS=D	144G.61 Subd. 2 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;	01370		

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01370	Continued From page 34 (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 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 and competency evaluations were completed as	01370		

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01370	Continued From page 35 required prior to providing direct care for one of two unlicensed personnel (ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting ULP-D started employment and began providing assisted living services on September 22, 2021. On November 4, 2021, at approximately 7:35 a.m. ULP-D was observed to provide personal cares to R3. ULP-D's employee record contained a transcript which listed various training; however, the transcript lacked evidence of the above required topics. On November 5, 2021, at approximately 10:45 a.m. licensed assisted living director (LALD) verified the above topics had not been completed.	01370		

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01370	Continued From page 36 The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training and competency evaluations would include: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of	01380		

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01380	Continued From page 37 two unlicensed personnel (ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas: - recognizing physical, emotional, cognitive, and developmental needs of the resident ULP-D started employment and began providing assisted living services on September 22, 2021. On November 4, 2021, at approximately 7:35 a.m. ULP-D was observed to provide personal cares to R3. ULP-D's employee record contained a transcript which listed various training; however, the transcript lacked evidence of the above required topic. On November 5, 2021, at approximately 10:45 a.m. licensed assisted living director (LALD) verified the above topic had not been completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training and	01380		

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01380	Continued From page 38 competency evaluations would include: - recognizing physical, emotional, cognitive, and developmental needs of the resident No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 39 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a	01470		

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	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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
01470	Continued From page 40 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-B RN-B started employment on February 16, 2016, and began providing assisted living services on August 1, 2021. RN-B's employee record lacked evidence the employee had received the following required training: - a review of the types of assisted living services the employee would provide and the provider's scope of license On November 5, 2021, at approximately 11:45 a.m. RN-A verified the above required training had not been completed. ULP-C ULP-C started employment on January 20, 2020, and began providing assisted living services on August 1, 2021. On November 4, 2021, at approximately 7:35 a.m. ULP-C and ULP-D were observed to provide cares to R3. ULP-C's employee record lacked evidence the employee had received the following required	01470		

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01470	Continued From page 41 training: - an overview of the assisted living statutes; and - a review of the types of assisted living services the employee would provide and the provider's scope of license On November 5, 2021, at approximately 11:40 a.m. RN-B and licensed assisted living director (LALD) verified the above required training had not been provided. ULP-D ULP-D started employment and began providing assisted living services on September 22, 2021. ULP-D's employee record lacked evidence the employee had received the following required training: - an overview of the assisted living statutes; and - a review of the types of assisted living services the employee would provide and the provider's scope of license (the employee's file contained a copy of a Uniform Disclosure of Assisted Living Services and Amenities for a different provider.) On November 5, 2021, at approximately 10:45 a.m. RN-B and LALD verified the above required training had not been provided. The licensee's Orientation of Staff and Supervisors Content policy dated August 1, 2021, noted orientation must be completed once for each staff before providing assisted living services to residents, and must contain: - an overview of the appropriate assisted living statutes and rules; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure	01470		

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01470	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=E	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 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 observation, interview and record	01530		

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01530	Continued From page 43 review, the licensee failed to ensure three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C and ULP-D) received the required amount of dementia care training, in the required time frame 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an assisted living license. During the entrance conference on November 3, 2021, at approximately 10:05 a.m. licensed assisted living director (LALD) and RN-B stated the licensee currently had no residents with the diagnosis of dementia. RN-B RN-B started employment on February 16, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-B's employee record contained evidence the employee had received 1.75 hours training, but lacked the 2.0 hours required annually.	01530		

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01530	Continued From page 44 On November 5, 2021, at approximately 11:45 a.m. RN-B verified the above required training had not been completed. ULP-C ULP-C started employment on January 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On November 4, 2021, at approximately 7:35 a.m. ULP-C and ULP-D were observed to provide cares to R3. ULP-C's employee record contained evidence the employee had received 2.25 hours training, and not the required 8 hours of training within 160 working hours. On November 5, 2021, at approximately 11:40 a.m. RN-B and LALD verified the above required training had not been provided, and stated ULP-C had reached 160 working hours on February 22, 2020. ULP-D ULP-D started employment and began providing assisted living services on September 22, 2021. ULP-D's employee record contained evidence the employee had received 7.75 hours training, and not the required 8 hours of training within 160 working hours. On November 5, 2021, at approximately 10:45 a.m. RN-B and LALD verified the above required training had not been provided, and stated ULP-D had reached 160 working hours on October 25,	01530		

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01530	Continued From page 45 2021. The licensee's Dementia Training policy dated August 1, 2021, noted direct-care staff would complete 8 hours initial training within 160 working hours, and all staff would complete two hours additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 46 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included 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). The findings include: R1's service plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - a contingency plan that includes: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to administer insulin to R1.	01650		

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01650	Continued From page 47 R1's Service Plan dated October 15, 2021, indicated the resident received assistance with medication administration. In addition, the plan noted the following in different areas under monitoring and reassessment schedule, neither of which were all inclusive. - initial and every 90 days thereafter, or when there is a change in condition; and - initial, 14 day, and every 90 days thereafter, or when there is a change in condition The service plan also had a section to identify the resident's declarations made under chapters 145B and 145C, but was left blank. On November 3, 2021, at approximately 3:25 p.m. registered nurse (RN)-B confirmed the resident's service plan lacked the required content. In addition, RN-B stated the same template was utilized for all residents. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a description of the services that would be provided, the schedule for the next planned assessment or monitoring, and a contingency plan that included how the facility would support documented resident health care directive decisions, if any, including circumstances when emergency medical services were not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 48 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement and maintain current written medication management policies and procedures that were developed	01690		

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01690	Continued From page 49 under the supervision and direction of a registered nurse (RN). In addition, the licensee failed to ensure the security and accountability of controlled substances being managed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: POLICIES During the entrance conference on November 3, 2021, at approximately 10:05 a.m. RN-B confirmed the licensee provided medication management services to the licensee's residents. The provided policies and procedures lacked the following: - verifying that prescription drugs are administered as prescribed; and - monitoring and evaluating medication use On November 3, 2021, at approximately 1:50 p.m. RN-B confirmed a policy related to the above required topics was not available. CONTROLLED SUBSTANCES The licensee lacked evidence of maintaining consistent security and accountability of controlled medications. On November 3, 2021, at approximately 12:00	01690		

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01690	Continued From page 50 p.m. the medication cart was reviewed with RN-B. The following was observed and confirmed with RN-B. A Controlled Substance Count and Supply Change Log was reviewed dated October 2021. The form lacked a second initial for the count between shifts on October 13, 2021, for lorazepam 0.5 milligram (mg). In addition, the back of the log was observed to have two columns drawn, one for October 2 (meant for November 2) and one for November 3, with the count noted and initials of staff for between shifts. At this time, RN-B confirmed the November log had not been printed, and staff were placing the count on the back; however, the back did not identify what had been counted. The licensee's Narcotic Log policy dated August 1, 2021, noted all controlled substances would be counted and recorded on the narcotic count sheet and compared with the quantities listed in the narcotic log book, at the start of the day shift and during the evening shift. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be	01700		

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01700	Continued From page 51 provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided 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 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	01700		

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01700	Continued From page 52 situation has occurred only occasionally). The findings include: During the entrance conference on November 3, 2021, at approximately 10:05 a.m. RN-B confirmed the licensee provided medication management services to the licensee's residents. R1's record lacked evidence the RN had conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to administer insulin to R1. R1's Medication Assessment dated September 26, 2021, noted the RN must identify and review all medications the resident was taking. The resident's prescriber orders dated October 11, 2021, included Basaglar (an injectable medication for diabetes) 28 units daily. R1's Service Plan dated October 15, 2021, indicated the resident received assistance with medication administration. The resident's October 2021, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. On November 3, 2021, at approximately 3:25 p.m. RN-B confirmed the above required content was not noted on the medication assessment as required.	01700		

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01700	Continued From page 53 A medication assessment policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R1) observed with insulin administration via a prefilled insulin pen, 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	01760		

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01760	Continued From page 54	01760		

resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's insulin was not administered according to the manufacturer's instructions.

R1's Service Plan dated October 15, 2021, indicated the resident received assistance medication administration.

The resident's prescriber orders dated October 11, 2021, included Basaglar (an injectable medication for diabetes) 28 units daily.

The resident's October 2021, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given.

On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to administer insulin to R1. ULP-E dialed the insulin pen, and went back to zero, and dialed again, showing 28 units on the pen. ULP-E administered the insulin to R1 in his abdomen, and returned to the medication cart. At this time, ULP-E stated she dialed the pen to 2 units, dialed it back to 0, and then dialed again to the 28 units to administer to the resident. ULP-E confirmed she did not prime the pen by ejecting 2 units, prior to dialing to the prescribed dose. In addition, ULP-E stated she had not been trained to eject the 2 units, and thought she had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 55 trained by a supervisor. On November 5, 2021, at approximately 10:05 a.m. registered nurse (RN)-B confirmed the staff should dial the insulin pen to 2 units, eject the 2 units, and then dial the insulin pen to the prescribed dose. The manufacturer's instruction for the use of the Basaglar insulin pen dated July 2021, instructed to prime the pen before each injection, by turning the dose to 2 units, tapping the cartridge holder gently to collect air bubbles at the tope, and pushing the dose knob until it stops and returns to 0. It also indicated not priming the pen prior to each injection may result in too much or too little insulin. The licensee's Insulin policy dated August 1, 2021, lacked instruction on priming the insulin pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.	01930		

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01930	Continued From page 56 (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 3, 2021, at approximately 10:05 a.m. RN-B confirmed the licensee provided treatment management services. A request was made to review the licensee's policies and procedures. The provided policies and procedures failed to	01930		

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01930	Continued From page 57 address: - monitoring and evaluating the treatment or therapy On November 3, 2021, at approximately 1:50 p.m. RN-B confirmed the licensee lacked the above required policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940		

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01940	Continued From page 58 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided for one of one resident (R1) who had a prescribed treatment or therapy, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan lacked a written statement to include prescribed blood glucose monitoring. On November 5, 2021, at approximately 8:50 a.m. unlicensed personnel (ULP)-E was observed to perform a blood glucose check and administer insulin to R1. R1's Individualized Treatment or Therapy Management Plan dated September 26, 2021, identified blood glucose monitoring as a service	01940		

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	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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
01940	Continued From page 59 that would be provided. R1's Service Plan dated October 15, 2021, indicated the resident received assistance with medication administration; however, the service plan lacked identification of the prescribed blood glucose monitoring to be provided. R1's October 2021, Medication Record noted blood glucose checks completed twice daily, with staff initials beginning October 14, 2021, to current indicating the treatment had been provided. On November 3, 2021, at approximately 3:25 p.m. registered nurse (RN)-B confirmed the resident's service plan lacked identification of blood glucose monitoring. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a description of the services that would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is	03000		

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	35678	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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03000	Continued From page 60	03000		

admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:
(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of

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GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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03000	Continued From page 61 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 3, 2021, at approximately 10:05 a.m. a request was made to the licensed assisted living director (LALD) and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2021. LALD and RN-B stated at this time no reports had been submitted to MAARC in this time period. On November 4, 2021, at approximately 8:00 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R2 in his room. R2's diagnoses included seizures and traumatic brain injury. R2's Service Plan dated June 11, 2021, indicated	03000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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03000	Continued From page 62	03000		

the resident received services that included, but were not limited to, medication administration, food preparation and catheter cares.

A Complaint Form dated August 24, 2021, noted a peer had called former house manager (FHM) and stated R2 had not received supper, indicating staff refused to give it to R2. A note signed by FHM, stated ULP-G had refused to give R2 his supper, because they were waiting for the resident to say how he wanted his waffle cut up. FHM spoke with R2 and ULP-G, and the food was provided.

On November 3, 2021, at approximately 11:25 a.m. licensed assisted living director (LALD) stated the supervisor had called the house and corrected staff, who provided food to R2 at that time. LALD stated ULP-G was terminated and did not work again after that date. LALD verified withholding food would be considered a form of abuse, and stated she did not believe the incident had been reported to MAARC. At 11:55 a.m., LALD verified the incident had not been reported to MAARC.

The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted if the LALD or clinical nurse supervisor confirmed the suspicion of maltreatment they would contact MAARC within 24 hours.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

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03090	Continued From page 63	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. 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 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 3, 2021, at approximately 9:05 a.m. upon entering the facility, an observation outside and inside the front entrance revealed no posting for electronic monitoring devices as required.	03090		

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03090	Continued From page 64 On November 3, 2021, at approximately 11:15 a.m. licensed assisted living director (LALD) verified electronic monitoring is utilized in the common areas, and confirmed the licensee lacked the proper signage with the statutory language. The licensee's Electronic Monitoring policy dated August 1, 2021, noted signs would be posted at each entrance accessible to visitors to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/03/21*
Time: 11:55:56
Report: 8042211172

Food and Beverage Establishment Inspection Report

Location:
Generations Home Care Inc
119 3rd Avenue Se
St Joseph, MN56374
Stearns County, 73

Establishment Info:
ID #: 0038412
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202828074
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11C ** Priority 1 **

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

DISH MACHINE IS NOT OPERATIONAL. DISHES ARE BEING WASHED, RINSED, AND SANITIZED IN A 2 COMPARTMENT SINK THAT IS ALSO USED AS THE HAND WASHING SINK. REPAIR OR REPLACE THE DISH MACHINE TO PROPERLY CLEAN/SANITIZE DISHES.

Comply By: 11/03/21

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.

DATE MARK OPEN PACKAGE OF SLICED HAM AND LEAF LETTUCE IN UPRIGHT COOLER.

Comply By: 11/03/21

2-100 Supervision

2-102.12AMN

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

PROVIDE A CERTIFIED FOOD PROTECTION MANAGER FOR ESTABLISHMENT.

Comply By: 12/01/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

DISCONTINUE STORING A BOX OF CHIPS ON THE FLOOR IN THE DRY STORAGE ROOM. DISCONTINUE STORING WATER SOFTENER SALT ON THE FLOOR IN THE BASEMENT.

Comply By: 11/03/21

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DISCONTINUE COOKING IN A DOMESTIC CROCK POT.

Comply By: 11/03/21

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DISCARD CHICKEN SALAD IN UPRIGHT COOLER DATED 11-2. TCS FOODS CANNOT BE HELD FOR MULTIPLE DAYS UNLESS THE KITCHEN MEETS PARAMETERS OF A COMMERCIAL KITCHEN.

Comply By: 11/03/21

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: 2 COMPARTMENT SINK BASIN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: CHICKEN SALAD
Violation Issued: No

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

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 8042211172 of 11/03/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: EH_____

Establishment Representative 8042

651-201-4500
health.foodlodging@state.mn.us

Report #: 8042211172

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	3	Date	11/03/21
No. of Repeat RF/PHI Categories Out	0	Time In	11:55:56
Legal Authority MN Rules Chapter 4626		Time Out	

Generations Home Care Inc	Address: 119 3rd Avenue Se	City/State: St Joseph, MN	Zip Code: 56374	Telephone: 3202828074
License/Permit #: 0038412	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/03/21

Inspector (Signature) EH