



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 14, 2025

Licensee

Gentle Care Homes Inc.
8308 49th Avenue North
New Hope, MN 55428

RE: License Number 414158
Health Facility Identification Number (HFID) 36229
Project Number(s) SL36229015

Dear Licensee:

On December 31, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 7, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 31, 2024.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 31, 2024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on December 31, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1380 - Training And Evaluation Of Unlicensed Personnn - 144g.61 Subd. 2 (b) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 31, 2024 (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 approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on December 31, 2024, we identified the following violation(s):

1370 - Training And Evaluation Of Unlicensed Person - 144g.61 Subd. 2 (a)

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

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 may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2024
NAME OF PROVIDER OR SUPPLIER GENTLE CARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8308 49TH AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL36229015-1 On December 31, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 7, 2024. At the time of the survey, there were three(3) residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	{0 810}			

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{0 810}	Continued From page 3 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370			

Minnesota Department of Health

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01370	Continued From page 4 (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 interview and record review, the licensee failed to ensure required competency training was completed for three of three unlicensed employees (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01370			

Minnesota Department of Health

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01370	Continued From page 5 ULP/AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's record lacked documentation of required training and competency evaluations to be completed in the following areas: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. ULP/AM-A's record lacked documentation of required competency evaluation in standby techniques and how to perform them. ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services. ULP-C's employee record lacked the following documentation of required training and competencies: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting;	01370			

Minnesota Department of Health

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01370	Continued From page 6 -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. ULP-C's record lacked documentation of required competency evaluation in standby techniques and how to perform them. ULP-D ULP-D was hired on May 22, 2023, and began providing assisted living services. ULP-D's employee record lacked the following documentation of required training and competencies: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; and -standby assistance techniques and how to perform them; On December 31, 2024, at 12:45 p.m., licensed assisted living director (LALD)-E reviewed ULP/AM-A, ULP-C, and ULP-D's records with the surveyor and stated they could not find the missing training and competency documentation in the records. On December 31, 2024, at approximately 1:25 p.m. LALD-A stated they had assigned the missing training to ULP/AM-A, ULP-C and ULP-D and planned to have the nurse complete the competency evaluations. The licensee's undated 5.02 Competency	01370			

Minnesota Department of Health

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01370	Continued From page 7 Training Evaluation policy indicated training and competency evaluations for all ULPs will include: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
{01380} SS=F	144G.61 Subd. 2 (b) 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	{01380}			

Minnesota Department of Health

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{01380}	Continued From page 8 required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required training and competency evaluation was completed for three of three unlicensed employees (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP/AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's record lacked documentation of required competency evaluations to be completed in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services.	{01380}			

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{01380}	Continued From page 9 ULP-C's employee record lacked the following documentation of required competency evaluations: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-D ULP-D was hired on May 22, 2023, and began providing assisted living services. ULP-D's employee record lacked the following documentation of required training and competency evaluations: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On December 31, 2024, at 12:45 p.m., licensed assisted living director (LALD)-E reviewed ULP/AM-A, ULP-C, and ULP-D's records with surveyor and stated he could not find the missing training and competencies in the records. On December 31, 2024, at approximately 1:25 p.m. LALD-A stated they had assigned the missing training to ULP/AM-A, ULP-C and ULP-D and planned to have the nurse complete the competency evaluations. The licensee's 5.02 Competency Training Evaluations policy, undated, indicated training and competency evaluation would include the following: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning.	{01380}			

Minnesota Department of Health

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{01380}	Continued From page 10 No further information was provided.	{01380}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 10, 2024

Licensee

Gentle Care Homes Inc.

8308 49th Avenue North

New Hope, MN 55428

RE: Conditional License Number 414158
Health Facility Identification Number (HFID) 36229
Project Number(s) SL36229015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 8, 2025**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$500.00. **MDH is not imposing these fines against your license at this time.**

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction 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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED

MDH will issue Gentle Care Homes Inc. a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the

follow-up survey, MDH will determine if Gentle Care Homes Inc. is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Gentle Care Homes Inc. will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Gentle Care Homes Inc. must provide the Department:
 - i. A list of the names and birthdates of any individuals Gentle Care Homes Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Gentle Care Homes Inc. will contract with an RN to provide consultation concerning all resident(s) to whom Gentle Care Homes Inc. provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Gentle Care Homes Inc. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Gentle Care Homes Inc. and MDH must review the RN’s credentials and approve the selection. Gentle Care Homes Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Gentle Care Homes Inc. in an effort to help Gentle Care Homes Inc. align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Gentle Care Homes Inc. will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and

substantial compliance with statutory requirements.

- d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Gentle Care Homes Inc. and the RN consultant about a change. Each report will be electronically submitted to Jess Schoenecker, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jess.schoenecker@state.mn.us. Jess Schoenecker can be reached at 651-201-3789 (office) with questions about reports. The content of the reports will include information such as:

 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Gentle Care Homes Inc. to correct the violations cited during the survey as well as to determine the overall practice of Gentle Care Homes Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Health Facility Construction Permit:** Gentle Care Homes Inc., will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Gentle Care Homes Inc.,

will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

- h. General Contractor:** Gentle Care Homes Inc. must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of this notice:

 - i. Name
 - ii. License Number
 - iii. Contact Information
- i. Egress Window Requirements:** Gentle Care Homes Inc. will replace at least one window in occupied resident sleeping room #4 meeting the minimum size requirements.

 - i. Must have a minimum openable width of no less than 20 inches
 - ii. Must have a minimum openable height of no less than 20 inches
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
 - v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge
- j. Corrective Action Plan:** Gentle Care Homes Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD

MDH will determine if Gentle Care Homes Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Gentle Care Homes Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Gentle Care Homes Inc.'s assisted living facility license, and Gentle Care Homes Inc. will correct any outstanding violations identified during the survey. If Gentle Care Homes Inc. is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

Gentle Care Homes Inc.

October 10, 2024

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REQUESTING A HEARING

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Jess Schoenecker directly at: 651-201-3789.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER GENTLE CARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8308 49TH AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36229015-0 On August 5, 2024, through, August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) resident(s); 4 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 6, 2024, issued for SL36229015-0, tag identification 0820. The immediatcy of correnction order for tag identification 0820 was not cleared at the time the survey was closed on August 7, 2024.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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;	0 250			

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the 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 met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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: During the entrance conference on August 5,	0 250			

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0 250	Continued From page 3 2024, at 10:45 a.m., unlicensed personnel/assistant manager (ULP/AM)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six 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, 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. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250			

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets 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 a license. I understand that information submitted to the commissioner in this 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 or 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, and Minnesota Rules, chapter 4659 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.	0 250			

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0 250	Continued From page 5 - 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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by owner licensed assisted living director (LALD)-E on May 16, 2022. On May 26, 2022, an Assisted Living license was issued to licensee. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control plan and practices; - contract content; -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with United States Centers for Disease Control and Prevention standards. -service plans; and -delegation of tasks by registered nurses or licensed health professionals. On August 7, 2024, at approximately, 8:30 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided assisted living services but failed to develop and implement corresponding	0 250			

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0 250	Continued From page 6 policies and procedures as required. CNS-B stated policies had been purchased but not implemented and were unable to be located. As a result of this survey, the following orders were issued 0250, 0470, 0480, 0510, 0550, 0580, 0640, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0820, 0900, 0950, 1380, 1470, 1500, 1530, 1620, 1640, 1760, 1820, 1830, 1880, 1940, 1950, 1960, and 3090 indicating 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. 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	0 470			

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0 470	Continued From page 7 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 staffing plan was developed as required, potentially affecting the licensee's four 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 the residents). The findings include: 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	0 470			

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0 470	Continued From page 8 - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On August 7, 2024, at approximately 8:12 a.m., clinical nurse supervisor (CNS)-B stated they did not have a staffing plan other than the names of daily staff that were written on a whiteboard in a common area. CNS-B stated she was unaware of the requirement for a staffing plan that was reviewed twice yearly. The licensee's undated Staffing 4659.0180 policy indicated the CNS must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480			

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0 480	Continued From page 9 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 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.	0 510			

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0 510	Continued From page 10 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 when the licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for two of two observed staff (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP/AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. On August 5, 2024, at approximately 1:30 p.m., ULP/AM-A was observed providing wound care to R2. ULP/AM-A applied gloves prior to the procedure without performing HH. ULP/AM-A removed a soiled dressing from R2's abdominal wound and disposed of the soiled dressing. ULP/AM-A then applied a new dressing without changing gloves or performing HH.	0 510			

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0 510	Continued From page 11 ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services. On August 5, 2024, at approximately 1:00 p.m., ULP-C was observed administering medications to R2. ULP-C opened the medication cabinet and applied gloves. HH was not observed. ULP-C set up R2's medications, brought them to R2's room and set them on a bedside table. ULP-C removed gloves and did not perform HH. On August 5, 2024, at approximately 1:45 p.m., ULP/AM-A and ULP-C stated that they had been trained in infection control techniques through EduCare (online education courses). On August 6, 2024, at approximately 8:30 a.m., clinical nurse supervisor (CNS)-B stated she observed staff each time she was at the facility and provided coaching and re-education as needed. On August 7, 2024, at approximately 9:45 a.m., CNS-B stated the licensee did not have an infection control plan. The licensee's undated Infection Control policy read "to practice hand hygiene, keep your hands clean by either washing with soap and water or using an alcohol-based sanitizer. Change gloves frequently and perform hand hygiene each time gloves are changed as dirty gloves can spread germs too. Also, do not wear the same pair of gloves for more than one resident." The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised April	0 510			

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0 510	Continued From page 12 12, 2024, indicated standard precautions were to be used to care for all patients (residents) in all settings, including HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient. b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. c. Before moving from work on a soiled body site to a clean body site on the same patient. d. After touching a patient or the patient's immediate environment. e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the	0 550			

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0 550	Continued From page 13 individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities. This had the potential to affect all four (4) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at approximately 11:30 a.m., during a facility tour, the surveyor observed the common areas of the facility lacked a posting of the grievance procedure and OOLTC contact information. On August 5, 2024, at approximately 11:45 a.m., unlicensed personnel/assistant manager (ULP/AM)-A stated the grievance information was not posted in the common area and stated they did not know it was a required posting. The licensee's undated Grievance Policy did not address the posting of the complaint process or	0 550			

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0 550	Continued From page 14 the required contents of the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that sis 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	0 580			

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0 580	Continued From page 15 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 August 5, 2024, at approximately 10:50 a.m., during the entrance conference, unlicensed personnel/assistant manager (ULP/AM)-A stated they did not know if the licensee had a QMP and was unaware if quality management meetings were held. On August 7, 2024, at 8:12 a.m., licensed assisted living director (LALD)-E and clinical nurse supervisor (CNS)-B stated they did not have a current quality management plan. The licensee's undated 2.31 Quality Management Project policy read "[Name of AL] would have at least one documented quality management project in place at all times and retain records of such projects for at least two years." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640			

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0 640	Continued From page 16 (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required and failed to post the 911 emergency number in common areas and by telephones. 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 August 5, 2024, at approximately 11:30 a.m., during a facility tour, the facility entry and common areas were observed to lack the required posting of the information and reporting number for MAARC and the required posting of the 911 emergency number. On August 5, 2024, at approximately 11:45 a.m., unlicensed personnel/assistant manager (ULP/AM)-A stated they were unaware of the	0 640			

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0 640	Continued From page 17 posting requirement for MAARC and 911 emergency number information. The licensee's undated Maltreatment of Vulnerable Adults (626.557) policy indicated [licensee] would post the following information: -the 911 emergency number in common areas and near telephones provided by the assisted living facility; and -information and the reported number for the MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650			

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0 650	Continued From page 18 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C, ULP-D). 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: ULP/AM-A ULP-AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's employee record lacked the following required content: -annual performance reviews for 2022 and 2023; and - demonstrated competencies for the following: -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food	0 650			

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0 650	Continued From page 19 safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -awareness of commonly used health technology equipment and assistive devices; and -medication administration on all route procedures. ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services. ULP-C's employee record lacked the following required content: -annual performance reviews for 2022 and 2023; and -demonstrated competencies for the following: --standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -awareness of commonly used health technology equipment and assistive devices; and -medication administration on all route procedures ULP-D ULP-D was hired on May 22, 2023, and began providing assisted living services. ULP-D's employee record lacked the following required content: -annual performance review for 2024; and -demonstrated competencies for the following: -reports of changes in the resident's condition to the supervisor designated by the facility; -standby assistance techniques and how to perform them;	0 650			

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0 650	Continued From page 20 -awareness of commonly used health technology equipment and assistive devices; and -medication administration on all route procedures. On August 7, 2024, at approximately 9:45 a.m., CNS-B stated she was unaware of how performance evaluations were handled. CNS-B stated she had never had a formal performance evaluation, but had frequent individual meetings with licensed assisted living director (LALD)-E. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated she trained all staff and did not know why competencies were missing from the files. CNS-B stated licensed assisted living director (LALD)-E had been re-organizing employee files, so he would know where additional training records are kept. The licensee's undated 4.05 Employee Records policy indicated employee records would include: -documentation of annual performance reviews that identify areas of improvement needed and training needs; and -records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660			

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0 660	Continued From page 21 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 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) which included maintaining a current Facility TB Risk Assessment and baseline screening and testing for one of two employees (unlicensed personnel (ULP)-D). 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:	0 660			

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0 660	Continued From page 22 The Facility TB Risk Assessment dated July 7, 2023, indicated the facility was a low risk setting for TB transmission. The Facility TB Risk Assessment had not been completed in the past twelve months and did not include current information. ULP-D was hired May 22, 2023, and began providing assisted living services. ULP-D's employee record lacked a TB history and symptom screen and results of a TB test. On August 6, 2024, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-B stated she was unaware that ULP-D's record was missing TB screening and testing. CNS-B stated, "I guess that one is just missing." On August 7, 2024, at approximately 10:00 am, CNS-B stated the licensee did not have a policy for TB screening and prevention. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a 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	0 660			

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0 660	Continued From page 23 (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680			

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NAME OF PROVIDER OR SUPPLIER GENTLE CARE HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 8308 49TH AVENUE NORTH NEW HOPE, MN 55428			
(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
0 680	Continued From page 24 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: The licensee's EP plan revised March 2, 2023, lacked the following required content: -an annual review of the EP plan; -a facility and community-based hazard vulnerability assessment categorizing risk by likelihood of occurrence; -a quarterly review of the missing resident plan; -a process for collaboration with local, tribal, regional, State and Federal EP to maintain an integrated response; -a system to track the location on on-duty staff and sheltered residents; -policies for medical documentation that preserves resident information, protects confidentiality, and maintains availability of records; -policies addressing the use of volunteers and the process/role for integration; -policies for providing care at alternate sites under the 1135 waiver; -a written communication plan that is reviewed/updated annually and includes: -contact information for staff, entities providing services under agreement, physicians, volunteers; -contact information for Federal, State, tribal, regional and local staff, state licensing agency, MN Office of the Ombudsman for Long-Term	0 680			

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0 680	Continued From page 25 Care; -means to provide information about the facility's occupancy, needs, and its ability to provide assistance; and -documented exercises at least twice per year to test the EP plan including analysis of the facility's response and revision to the plan as needed. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated she was unaware of the missing content of the EP plan and licensed assisted living director (LALD)-E was responsible for the plan. The licensee's undated Disaster Planning and Emergency Preparedness Plan policy indicated the EP plan would align with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. The licensee's undated Missing Resident policy read "[Licensee] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	0 780			

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0 780	Continued From page 26 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 licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780			

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0 780	Continued From page 27 The findings include: On August 06, 2024, from approximately 11:05 a.m. to 1:10 p.m., survey staff toured the facility with unlicensed personnel (ULP)-D. Survey staff tested the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. The smoke alarms were not interconnected throughout the facility. These deficient conditions were visually verified by ULP-D accompanying on the tour and he stated that he understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

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0 790	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 06, 2024, at approximately 11:05 a.m. to 1:10 p.m., survey staff toured the facility with unlicensed personnel (ULP)-D. The portable fire extinguisher in the basement did not have the correct classification size. The fire extinguisher in the basement had a classification size of 1-A:10BC and should be 2-A:10BC. On August 06, 2024, at approximately 11:05 a.m. to 1:10 p.m., survey staff conducted a facility tour with ULP-D, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. UPL-D stated they understood the requirements. No further information was provided.	0 790			

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0 790	Continued From page 29	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 06, 2024, from approximately 11:05	0 800			

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0 800	Continued From page 30 a.m. to 1:10 p.m., survey staff toured the facility with unlicensed personnel (ULP)-D. The following was observed. GENERAL MAINTENANCE: Carpet in the basement was wet due to a unknown cause. Several cigarette burns were discovered on the windowsill and on the wooden floor in bedroom #3. Ventilation vent in the main entryway was coming off the wall. ULP-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810			

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0 810	Continued From page 31 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810			

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0 810	Continued From page 32 On August 06, 2024, at approximately 12:30 p.m., unlicensed personnel (ULP)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. Emergency evacuation map did not show location and number of resident rooms. Emergency evacuation map did not have bedroom# 3 and bedroom#4 included on the emergency evacuation map. TRAINING and DRILLS: The licensee failed to provide evacuation training and drills to staff and residents as required. ULP-E stated that drills and training were being done but lacked documentation showing that any drills and training being offered. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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0 820	Continued From page 33	0 820			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 820			

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0 820	Continued From page 34 On August 06, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with unlicensed personnel (ULP)-D. During the tour, survey staff asked ULP-D to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: Window measured 30 inches clear width, 13.25 inches clear height, and 397.5 square inches total open area for each window. The window in bedroom 4 did not meet the minimum requirements for opening height. The window in bedroom 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On August 06, 2024, survey staff explained to ULP-D that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. The immediatcy of correnction order for tag identification 0820 was not cleared at the time the	0 820			

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0 820	Continued From page 35 survey was closed on August 7, 2024.	0 820			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 900			

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0 900	Continued From page 36 licensee failed to execute an assisted living (AL) contract before offering housing and assisted living services for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 was admitted on July 25, 2024, and began receiving assisted living services. R3's record included an unsigned Service Plan dated August 6, 2024, indicating R3's services included assistance with activities of daily living (ADLs), behavior management, medication administration, and meal assistance. R3's record included Progress Notes indicated R1 was receiving services on July 27, 2024. R3's record lacked a signed and executed assisted living contract. On August 5, 2024, unlicensed personnel/assistant manager (ULP/AM)-A stated R3's contract was not signed as he recently moved into the facility and his guardian had not yet signed his contract. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	0 900			

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0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the following verbatim notice to identify a designated representative for two of two residents (R1, R2).	0 950			

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NAME OF PROVIDER OR SUPPLIER GENTLE CARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8308 49TH AVENUE NORTH NEW HOPE, MN 55428		
(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
0 950	Continued From page 38 This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the clients). The findings include: R1 R1 was admitted on May 2, 2023, and began receiving assisted living services. R1's Service Plan (Waiver)-Addendum to Contract dated August 6, 2024, indicated R1's services included assistance with activities of daily living (ADLs), behavior management, and medication administration. R1's contract signed May 22, 2023, lacked a page or space for the resident to name a designated representative, or a space to initial if the resident declines to name a designated representative. R1's record lacked a separate Designated Representative notice containing the required statutory language. R2 R2 was admitted on September 1, 2022, and began receiving assisted living services. R2's record contained an unsigned Service Plan (Waiver)-Addendum to Contract dated August 6, 2024, indicating R2's services included assistance with ADLs, medication administration, behavior management, meal assistance, and	0 950			

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0 950	Continued From page 39 wound care. R2's contract signed September 1, 2022, included a space to name or decline a designated representative which had been left blank. The contract included the designated representative statutory language within the contract (page 2). R2's record lacked a separate Designated Representative notice containing the required statutory language. On August 7, 2024, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of the designated representative requirements in the contracts. CNS-B stated, "the licensed assisted living director takes care of that". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01380 SS=D	144G.61 Subd. 2 (b) 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,	01380			

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01380	Continued From page 40 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 competency testing was completed in all required areas for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the problem has occurred only occasionally). The findings include: ULP-D was hired on May 22, 2023, and began providing assisted living services. On August 6, 2024, at 7:16 a.m., ULP-D documented in R2's Progress Notes "vital signs are within normal limits". ULP-D's record lacked documentation the registered nurse (RN) had instructed and evaluated competency for the following: -reading and recording temperature, pulse, and respirations of the resident; and -range of motioning and positioning. On August 6, 2024, at approximately 3:00 p.m.,	01380			

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01380	Continued From page 41 licensed assisted living director (LALD)-E stated all employees were trained prior to administering medications or treatments. LALD-E stated he did not know where the training documentation was located. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated they had trained staff and did not know where training documentation was located as licensed assisted living director (LALD)-E had been re-organizing employee files. The licensee's 5.02 Competency Training Evaluations policy, undated, indicated training and competency evaluation would include the following: -reading and recording temperature, pulse, and respirations of the resident; -range of motioning and positioning; and -administering medications and treatments as provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=F	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;	01470			

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01470	Continued From page 42 (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 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	01470			

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01470	Continued From page 43 (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 interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of three employees (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-D). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all the residents). The findings include: ULP/AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's employee record lacked documentation of orientation to handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. ULP-D ULP-D was hired on May 22, 2023, and began	01470			

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01470	Continued From page 44 providing assisted living services. ULP-D's employee record lacked documentation of the following required orientation topics: -review of provider's policies and procedures; and -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates or other relevant advocacy services. On August 7, 2023, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-B stated they were unaware that specific topics were missing from orientation content. CNS-B stated orientation would need to be reviewed. The licensee's Staff Training and Orientation policy, undated, indicated the licensee's orientation topics would include: -handling of resident complaints, where to report complaints, including reports to the Office of Health Facility Complaints; and -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates or other relevant advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			

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01500	Continued From page 45	01500			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 46 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 challenges it poses to communication; (2) the 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 that one of three employees (unlicensed personnel (ULP)-C) completed a minimum of 8 hours of annual training per 12 months of employment. The licensee also failed to include all required content in the annual training for three of three employees (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01500			

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01500	Continued From page 47 The findings include: ULP-AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's employee record included a My Transcript dated August 6, 2024, indicating ULP/AM-A had completed online courses in March 2024, satisfying content required for annual training. ULP/AM-A's employee record lacked documentation of review of provider's policies and procedures required for annual training in March 2024. ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services. ULP-C's employee record included a My Transcript dated August 6, 2024, indicating ULP-C had completed online courses in during June 2023, to satisfy content required for annual training. ULP-C's employee record lacked documentation of the following content required for annual training for 2023: -reporting maltreatment of vulnerable adults or minors; and -review of provider's policies and procedures ULP-C's employee record lacked documentation of all content required for annual training for 2024.	01500			

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01500	Continued From page 48 ULP-D ULP-D was hired on May 22, 2023, and began providing assisted living services. ULP-D's employee file included a My Transcript dated August 6, 2024, indicating ULP-D had completed online education on the Minnesota Assisted Living Bill of Rights on July 15, 2024. ULP-D's employee file lacked documentation of the following content required for annual training for 2024: -reporting maltreatment of vulnerable adults or minors; -infection control techniques; -effective approaches to use to problem solve when working with resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of provider's policies and procedures; and -principles of person-centered planning and service delivery. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of missing content in annual education and EduCare (computer-based training) assignments would need to be reviewed. The licensee's Staff Training and Orientation policy, undated, did not address requirements for annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01530	Continued From page 49	01530			
01530 SS=F	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 interview and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for three of three employees (unlicensed personnel/assistant manager ((ULP/AM)-A, ULP-C, ULP-D) and failed to ensure two (2) hours of dementia training for each 12 months of employment was completed for two of three	01530			

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01530	Continued From page 50 employees (ULP-C, ULP-D). 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: ULP/AM-A ULP/AM-A was hired on September 19, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP/AM-A's employee record included three (3) hours of dementia care training completed on October 18, 2023, and two and one half (2.5) hours of dementia care training on March 15, 2024. ULP/AM-A's employee record lacked documentation of 8 hours of initial dementia care training completed within 160 working hours. ULP-C ULP-C was hired on August 1, 2021, and began providing assisted living services. ULP-C's employee record included 3 hours of dementia care training completed on June 11, 2023. ULP-C's employee record lacked documentation of 8 hours of initial dementia care training	01530			

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01530	Continued From page 51 completed within 160 working hours and lacked documentation of at least 2 hours of dementia care training for 2024 annual training. ULP-D ULP-D was hired on May 22, 2023, and began providing assisted living services. ULP-D's employee record included documentation of one hour of dementia care training completed on June 3, 2023. ULP-D's employee record lacked documentation of the required 8 hours of dementia care withing 160 working hours and lacked documentation of at least 2 hours of dementia care training for each 12 months of employment thereafter. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of the dementia care training requirements. The licensee's Staff Training and Orientation policy, undated, did not address dementia care training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 52 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and within the required 90-day timeframe for one of two residents (R2). 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 represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01620			

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01620	Continued From page 53 R2 was admitted on September 1, 2022, and began receiving assisted living services. R2's record included comprehensive assessments completed on September 2, 2022 (Admission Assessment), September 16, 2022, and December 6, 2022. R2's record lacked documentation of any additional assessments indicating 608 days had passed between R2's last assessment on December 6, 2022, and the initial survey date of August 5, 2024. On August 6, 2024, at approximately 8:50 a.m., clinical nurse supervisor (CNS)-B stated she was unaware assessments were required at least every 90 days and stated she had been completing assessments annually. The licensee's Initial and Continuing Assessments 4659.0140 policy, undated, indicted nursing assessments would be conducted in person according to Minnesota Statutes, section 144G.70, subdivision 2. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640			

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01640	Continued From page 54 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan that included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01640			

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01640	Continued From page 55 R1 R1 was admitted on May 22, 2023, and began receiving assisted living services. R1's record lacked a current written service plan to include a signature or other authentication by the facility and the resident documenting agreement on services to be provided. R2 R2 was admitted to on September 1, 2022, and began receiving assisted living services. R2's record lacked a current written service plan to include a signature or other authentication by the facility and the resident documenting agreement on services to be provided. R3 R3 was admitted on July 25, 2024, and began receiving assisted living services. R3's record lacked a current written service plan to include a signature or other authentication by the facility and the resident documenting agreement on services to be provided. On August 6, 2024, at approximately 8:30 a.m., clinical nurse supervisor (CNS)-B stated they were unaware residents were required to have a current signed service plan in their records. On August 6, 2024, at approximately 8:45 a.m., CNS-B provided surveyor with a Service Plan (Waiver)- Addendum to Contract for R1, R2, and R3, unsigned by facility or resident and dated August 6, 2024 (during the survey process). No further information was provided.	01640			

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01640	Continued From page 56	01640			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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 the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-C) observed administering medications for one of two residents (R2). 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	01760			

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01760	Continued From page 57 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on September 1, 2022, and began receiving assisted living services. R2's diagnoses included diabetes type two, unspecified open wounds of abdominal wall, acute kidney failure, and schizoaffective disorder. R2's unsigned Service Plan (waiver) printed August 6, 2020 (during survey process), indicated R2's services included medication setup and administration. R2's 90-Day Assessment dated December 6, 2022, indicated R2 required medication management, setup, and administration. On August 5, 2024, at approximately 1:00 p.m., unlicensed personnel (ULP)-C was observed administering medications to R2. ULP-C failed to check medications against a medication administration record (MAR) during set-up of medication and left the medication at R2's bedside during administration, failing to observe R2 taking his medications. On August 5, 2024, at approximately 1:45 p.m., ULP-C stated he had been trained to give medications by the nurse. On August 6, 2024, at approximately 8:30 a.m., clinical nurse supervisor (CNS)-B stated she always watches the ULPs administer medications when she is at the facility. CNS-B stated the ULPs often forget to check medications against the MAR when they are preparing them, and she	01760			

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01760	Continued From page 58 is "working with them on that". The licensee's undated Medication/Treatment Management policy indicated the ULP will verify the medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01820			

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01820	Continued From page 59 R3 was admitted on July 25, 2024, and began receiving assisted living services. R3's unsigned Service Plan (Waiver) - Addendum to Contract dated August 6, 2024, indicated R2's services included medication setup and administration. R2's Medication Administration Summary for August 2024, indicated R2 was administered the following medications: -divalproex 500 milligrams (mg) extended release (ER) tablet, take one tablet by mouth (PO) two times daily; -docusate sodium 100 mg capsule, take one capsule PO two times daily; -haloperidol oral solution 2 mg/milliliter (ml), take one ml PO two times daily; -propranolol 10 mg tablet; take one tablet PO three times daily; -sucralfate 1 gram (G) tablet, take one tablet PO four times daily (before meals and at bedtime); -Vitamin D3 1,000 international units (iu), take two tablets PO once daily; and -olanzapine 20 mg tablet, take one tablet under tongue once daily at bedtime. R3's medical record lacked a signed prescriber order for all medications. On August 7, 2024, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-B stated R3's record did not contain prescriber orders for medications. CNS-B stated they would need to get signed orders at his next clinic visit. The licensee's Medication and Treatment Management policy, undated, indicated prior to unlicensed personnel providing delegated	01820			

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01820	Continued From page 60 medications and treatment, the medication would have a current prescriber order on file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of two residents (R2). 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: R2 R2 was admitted on September 1, 2022, and began receiving assisted living services.	01830			

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01830	Continued From page 61 R2's unsigned Service Plan (Waiver) - Addendum to contract printed August 6, 2024, indicated R2's services included medication setup and administration. R2's Medication Administration Summary dated August 2024, indicated R2 had been administered the following medications during the month: -acetaminophen 325 milligrams (mg) tablet, take three tablets by mouth (PO) three times daily; -aripiprazole 20 mg tablet, take one tablet PO daily -ferrous sulfate 325 mg tablet, take one tablet PO twice daily after meals; -glipizide extended release (ER) 10 mg tablet, take one tablet PO twice daily with meals; -Invokana 300 mg tablet, take one tablet PO daily; -lactase enzyme 300 unit tablet, take three tablets PO three times daily with meals; -Lantus Solostar 100 units/milliliter (ml), inject 50 units under skin nightly at bedtime; -mirtazapine 15 mg tablet, take one tablet PO at bedtime; -omeprazole 20 mg capsule, take one capsule PO once daily; -Sentry tablet, take one tablet PO daily; -Vitamin D3 25 micrograms (mcg) tablet, take one tablet PO daily; -metformin 500 mg ER tablet, take two tablets PO twice daily; and -Ondansetron 4 mg tablet, take one tablet under tongue three times daily as needed for nausea. R2's record included an unsigned MD Orders form for medication certification from May 20, 2024, through March 30, 2025. The form was unsigned and was printed on August 6, 2024 (during survey process).	01830			

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01830	Continued From page 62 On August 5, 2024, at approximately 1:00 p.m., unlicensed personnel (ULP)-C was observed administering medications to R2. On August 6, 2024, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-B stated R2 did not have a current renewal of prescriber orders. CNS-B stated the employees usually take the medication list to physician appointments for signature, but do not always return with authenticated orders. The licensee's undated Medication and Treatment Management policy indicated the registered nurse is responsible for ensuring current, authorized prescriber orders for medications or treatments administered by the staff are kept in the resident's file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications in securely locked and substantially constructed compartments according to the	01880			

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01880	Continued From page 63 manufacturer's directions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at approximately 11:45 a.m., the surveyor observed a small, unlocked refrigerator in the office. The refrigerator contained an empty locked box and two Lantus insulin pens labeled for R2. The refrigerator lacked a thermometer and documentation the refrigerator temperature was monitored. On August 5, 2024, at approximately 11:45 a.m., unlicensed personnel/assistant manager (ULP/AM)-A stated they did not monitor the temperature on the medication refrigerator. On August 7, 2024, at approximately 8:00 a.m., clinical nurse supervisor (CNS)-B stated the insulin pens should be stored in the locked box inside the refrigerator and the refrigerator temperature should be monitored. CNS-B stated, "that is a problem". Lantus Solostar patient instructions for use revised 2022, indicated the following: -after the first use, don't refrigerate the Lantus Solostar pen. Keep it at room temperature only (below 86 degrees Fahrenheit (°F)); -after 28 days, throw your opened Lantus pen away, even if it still has insulin in it;	01880			

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01880	Continued From page 64 Keep Lantus away from direct heat and light; and -don't leave Lantus in a hot car, in the direct sun, or in a freezing care. If Lantus gets too hot or freezes, it will have to be thrown away. The licensee's 7.11 Medication Storage policy, undated, read "when the medications are managed and stored by [Name of AL], medications will be kept securely locked and stored per manufacturer's directions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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	01940			

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01940	Continued From page 65 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2). 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: R2 was admitted on September 1, 2022, and began receiving assisted living services. R2's record lacked a signed service plan. R2's Service Delivery dated from July 1, 2024, through August 6, 2024, indicated R2 was receiving daily wound care. R2's After Visit Summary (AVS) dated July 24,	01940			

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01940	Continued From page 66 2024, included an order to test blood sugars three times a day by use of Freestyle Libre 2 Reader (continuous blood glucose monitor). R2's record lacked an individual treatment or therapy plan with all required content. On August 6, 2024, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated there wasn't an individualized treatment plan in R2's record. CNS-B stated, "it is an R-Task issue that will need to be corrected". The licensee's Medication and Treatment Management policy, undated, read "prior to unlicensed personnel (ULP) providing delegated medication administration and/or treatments/therapy, the following must occur: 1. A Registered Nurse much conduct a face-to-face resident assessment to determine what medication management or treatment and therapy services will be provided and how those services will be implemented. 2. [Licensee] will prepare and include in the service plan a written statement of the medication management or treatment/therapy services that will be provided to the resident. 3. The medications have current prescriber's orders on file. 4. A Registered Nurse must specify, in writing, specific instructions for each resident and document those instructions in the resident's record." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER GENTLE CARE HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 8308 49TH AVENUE NORTH NEW HOPE, MN 55428			
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01950	Continued From page 67	01950			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) instructed and ensured competency on proper treatment procedures for three of three unlicensed personnel (unlicensed personnel/assistant manager (ULP/AM)-A, ULP-C, ULP-D). The licensee also failed to ensure the RN specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of two residents (R2). 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	01950			

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01950	Continued From page 68 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 the residents). The findings include: R2 was admitted on September 1, 2022, and began receiving assisted living services. R2's unsigned Service Plan Waiver printed on August 6, 2024 (during survey process) indicated R2's services included daily wound care. R2's AVS from wound care clinic dated June 13, 2024, included the following instructions: 1. Okay to leave wound open to air. 2. Apply bacitracin to wound once daily to hep moisture and help with scabbing. 3. I do not recommend any more weight gain, because any more stretching of your abdomen, could cause your new scar tissue to re-open. R2's Services Delivered Record dated July 1, 2024, through August 6, 2024, indicated R2's wound care had been provided by ULP-D on August 1, 2024, at 7:32 a.m., and August 4, 2024, at 8:08 a.m. The record also indicated R2's wound care had been provided by ULP-C on August 8, 2026, at 8:54 a.m. R2's record lacked specific treatment instructions for R2's wound care. On August 5, 2024, at approximately 1:30 p.m., unlicensed personnel/assistant manager (ULP/AM)-A was observed providing wound care to R2. ULP-AM-A applied gloves and removed	01950			

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01950	Continued From page 69 soiled abdominal dressing from R2's abdomen. Without changing gloves or performing hand hygiene, ULP/AM-A washed R2's abdomen with an unlabeled bottle of solution poured onto 4 x 4 gauze pads. ULP/AM-A applied a petrolatum gauze dressing over the open area covered by a folded 4 x 4 gauze pad and secured with a bordered foam dressing. ULP/AM-A further secured the dressing with paper tape and then disposed of used dressing supplies and removed gloves. Hand hygiene following the treatment was not observed. Employee records for ULP/AM-A, ULP-C, and ULP-D lacked documentation the registered nurse (RN) had instructed and evaluated competencies in R2's wound care. On August 6, 2024, at approximately 9:25 a.m., ULP/AM-A stated they observe dressing changes at R2's wound care appointments and that is how they know how to provide wound care. On August 7, 2024, at approximately 9:45 a.m., clinical nurse supervisor stated she shows staff how to perform dressing changes. The licensee's undated Medication /Treatment Management policy indicated the following: -the RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record; -the ULP must demonstrate their ability to competently follow the delegated medications administration or treatment/therapy of a RN; and -written records, signed by an RN, would be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy.	01950			

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01950	Continued From page 70 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document blood glucose monitoring for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on September 1, 2022, and began receiving assisted living	01960			

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01960	Continued From page 71 services. R2's diagnoses included diabetes type two, unspecified open wounds of abdominal wall, acute kidney failure, and schizoaffective disorder. R2's record included blood sugar level readings between the dates of May 17, 2023, through September 19, 2023. R2's record lacked documentation of blood glucose readings from September 20, 2023, through August 5, 2024 (start of survey process). R2's After Visit Summary (AVS) dated July 24, 2024, included directions to test blood sugars three times daily through a Freestyle Libre 2 Reader (continuous blood glucose monitor). On August 5, 2024, at approximately 1:00 p.m., surveyor and unlicensed personnel/assistant manager (ULP/AM)-A observed R2 using the Freestyle Libre 2 reader to check a blood glucose reading with a result of 193. On August 6, 2024, at approximately 2:00 p.m., CNS-B stated R2 monitored his blood glucose readings through his phone, which automatically transmitted the information to his prescriber's office, and they would notify the licensee if there was a change in orders. Surveyor asked CNS-B how she would know if R2 needed immediate attention due to blood sugars that were too high or too low and CNS-B stated "well, the staff would call me". On August 6, 2024, at approximately 2:20 p.m., licensed assisted living director (LALD)-E stated blood sugar results had previously been documented until R2 started using the Freestyle	01960			

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01960	Continued From page 72 Libre 2 system and now the staff take the Freestyle Libre 2 reader to clinic appointments and the blood sugar results are downloaded from the reader at each appointment. LALD-E stated the physician told staff they no longer needed to record blood sugar results. On August 7, 2024, at approximately 9:30 a.m., CNS-B stated the ULP's "probably didn't realize they needed to record R2's blood sugars". CNS-B emailed surveyor of a screenshot of the blood glucose recording task created in RTask (an electronic documentation system) for R2. The task had been created on August 6, 2024, at approximately 2:25 p.m. (during survey process). The licensee's undated Medication/Treatment Management policy indicated the following would be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: -date; -time; -quantity of dosage; -method of administration of all prescribed legend (sic) and over-the-counter medications and or treatments/therapy; and -signature and title of the authorized person who provided the assistance and/or administration of medications, treatment, or therapy. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090			

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03090	Continued From page 73 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 included required statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive 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 August 5, 2024, at approximately 10:00 a.m., upon entering the facility, the surveyor observed an electronic monitoring notice that failed to include the required statutory language. On August 5, 2024, at approximately 11:00 a.m., unlicensed personnel/assistant manager (ULP/AM)-A stated they were unaware of the required language to be included in the electronic monitoring posting. The licensee's 2.15 Electronic Monitoring policy	03090			

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03090	Continued From page 74 undated, indicated the licensee will post an electronic monitoring 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 or activities". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 08/06/24
Time: 10:55:58
Report: 1023241171

Food and Beverage Establishment Inspection Report

Page 1

Location:

Gentle Care Homes Inc
8308 49th Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0038852
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123888667
ID #:

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

The following orders were issued during this inspection.

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO PLAN AVAILABLE FOR REVIEW AND NO BLEACH AVAILABLE ON SITE. SENT SAMPLE PLAN WITH REPORT.

Comply By: 08/06/24

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

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

HIGH TEMP ANSI 184 DISH MACHINE IN USE BUT OPERATOR STATED NO IRREVERSIBLE TEMPERATURE DEVICE AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 08/06/24

2-100 Supervision

2-102.12AMN

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

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:

<https://fmctraining.web.health.state.mn.us/search/index.cfm>

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Food and Beverage Establishment Inspection Report

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Comply By: 08/06/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
INSTRUCTED OPERATOR TO DISCARD WOODEN CUTTING BOARD AND UTENSILS.

Comply By: 08/06/24

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

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

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

Type: Full
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Gentle Care Homes Inc

Food and Beverage Establishment Inspection Report

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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 1023241171 of 08/06/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

MOHAMMAD HASSAN
PERSON IN CHARGE

Signed: _____

Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us