Electronically Delivered

September 4, 2024

Licensee
Gabby Care Homes LLC - Sam's House
1306 West River Road
Champlin, MN 55316

RE: Project Number(s) SL36012015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - SAM'S H	1306 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: SL36012015-0 On July 30, 2024, through, July 31, 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 three residents receiving services under the provider's Assisted Living Facility license. An immediate order for tag identification 0820 was identified and issued on July 31, 2024. The immediacy of the order was not removed prior to exit on July 31, 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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

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0 680	Continued From page 2 or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated EDP plan lacked evidence of the following required content: - procedures for tracking of staff; - policies and procedures for medical documents; - roles under a wavier declared by secretary; - methods for sharing information; - sharing information on occupancy/needs; and - LTC (long-term care) family notifications. On July 30, 2024, at 2:39 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D acknowledged the EDP plan was not complete and missed required information as they followed the old emergency operation plan and not the Appendix Z. CNS/LALD-D indicated the licensee would update the EDP plan to reflect the Appendix Z requirements. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 3 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the 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	0 780		

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0 780	Continued From page 4 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 July 31, 2024, from approximately 10:42 a.m. to 12:10 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-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. Bedroom 4 smoke alarm was not working. 2. The smoke alarms were not interconnected throughout the facility. Including the addition that is used for office space. These deficient conditions were visually verified by LALD/CNS-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		
0 800 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	0 800		

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0 800	Continued From page 5 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 July 31, 2024, from approximately 10:42 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. The following was observed. GENERAL MAINTENANCE: Several cigarette burns were discovered on the wooden floor in bedroom #1. Several cigarette butts were found all over the ground outside by the side doorsteps. The residents have a designated smoking area which is the side door entrance steps and they do have	0 800		

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0 800	Continued From page 6 a cigarette butt receptacle but some of the residents are not using it. On July 31, 2024, at 11:30 a.m., LALD/CNS-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. (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.	0 810		

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0 810	Continued From page 7 (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: On July 31, 2024, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-D 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 fire safety evacuation map and plan did not include the whole buildings layout. This building had an attached addition that was not included with the assisted living side. This addition is	0 810		

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0 810	Continued From page 8 being used by the staff for office space but should be included in the fire safety plan and emergency evacuation map. LALD/CNS-D stated that he understood how this can affect the assisted living side and that he would work on creating a new fire safety evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	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.	0 820		

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0 820	Continued From page 9 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 31, 2024, from approximately 10:30 a.m. to 11:30 a.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D. During the tour, survey staff asked CNS/LALD-D to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: Window measured 24.5 inches clear width, 19 inches clear height, and 465.5 square inches total open area. UNOCCUPIED SLEEPING ROOMS: Bedroom 3: Window measured 24.5 inches clear width, 19 inches clear height, and 465.5 square inches total open area. The windows in bedrooms 3, 4 did not meet the minimum requirements for opening width. The windows in bedrooms 3, 4 did not meet the minimum requirements for opening height. The windows in bedrooms 3, 4 did not meet the minimum requirements for total openable area.	0 820		

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0 820	Continued From page 10 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 CNS/LALD-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 July 31, 2024, survey staff explained to CNS/LALD-D that an immediate correction order was issued for the above findings. CNS/LALD-D stated they understood the requirements for egress windows and would contact the local vender to order the new windows and start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate. The immediacy of the order was not removed prior to exit on July 31, 2024.	0 820		
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	01500		

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01500	Continued From page 11 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. 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	01500		

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01500	Continued From page 12 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 annual training included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-A, ULP-B). 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: ULP-A ULP-A was hired on September 29, 2022, as a certified nurse assistant (CNA). On July 31, 2024, at 8:06 a.m., the surveyor observed ULP-A provide medication administration to resident (R3). ULP-A's personnel record lacked evidence of annual training for review of the provider's policies and procedures. ULP-B ULP-B was hired on March 6, 2023, as a CNA.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - SAM'S H	1306 WEST RIVER ROAD CHAMPLIN, MN 55316

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01500	Continued From page 13 ULP-B's personnel record lacked evidence of annual training for review of the provider's policies and procedures. On July 31, 2024, at 10:22 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they did not complete the annual training for review of the provider's policies and procedures as they were not aware this was an annual requirement and indicated they would incorporate this into their annual training for all employees. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff who provided direct care would complete annual training every 12 months and would include review of the provider's policies and procedures as required by statue. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	07/31/2024

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01620	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment within the required 90-day timeframe for two of two residents (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) 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 R2 was admitted on February 21, 2022, with a diagnosis of unspecified psychosis (disconnection from reality). On July 31, 2024, at 8:06 a.m., the surveyor	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	07/31/2024

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01620	Continued From page 15 observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2's Service Plan dated February 22, 2022, indicated R2's services included bathing assistance, behavior management, housekeeping, laundry, meal assistance, medication administration, and safety checks. R2's record included 90-day nursing assessments dated January 16, 2024, April 8, 2024, and July 11, 2024. The assessment completed July 11, 2024, indicated 94 days had passed since the prior assessment completed on April 8, 2024. R3 R3 was admitted on June 1, 2020, with a diagnosis of schizoaffective disorder, bipolar type. On July 31, 2024, at 8:20 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's Service Plan dated August 1, 2021, indicated R3's services included bathing assistance, behavior management, housekeeping, laundry, meal assistance, medication administration, safety checks, and assistance with shopping. R3's record included 90-day nursing assessments dated October 9, 2023, January 16, 2024, April 16, 2024, and June 24, 2024. The assessment completed January 16, 2024, indicated 99 days had passed since the prior assessment completed on October 9, 2023. The assessment completed April 16, 2024, indicated 91 days had passed since the prior assessment completed on January 16, 2024.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 16 On July 31, 2024, at 1:21 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the licensee did not have any other assessments between the dates provided for [R2 and R3] with late 90-day assessments and indicated their electronic medical record (EMR) program should have alerted the licensee when an assessment would be due, however, the licensee's EMR had some glitches in the past. CNS/LALD-D stated they would set up a second verifier to ensure they were not late on the 90-day assessments going forward. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring would not exceed 90 calendar days from the last date of assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *07/30/24*
Time: 13:00:00
Report: 1051241064

Food and Beverage Establishment Inspection Report

Location:

Gabby Care Homes Llc - Sam'S H
1306 West River Road
Champlin, MN55316
Hennepin County, 27

Establishment Info:

ID #: 0038947
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634441904
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: AMBIENT
Violation Issued: No

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

MET WITH NURSE SURVEYOR, RHAWNIE QUINEHAN.

DISCUSSED THE FOLLOWING WITH ASSISTANT DIRECTOR, SAM:

EMPLOYEE ILLNESS
REPORTABLE ILLNESSES AND SYMPTOMS
VOMIT CLEAN-UP PROCEDURE
HIGHLY SUSCEPTIBLE POPULATION

THE KITCHEN HAS A NSF 184 DISHMACHINE, MDF WOODEN CABINETS, LAMINATE AND HOLLOW BASE COUNTERTOPS, SMOOTH TEXTURE CEILING, AND A LAMINATE FLOOR.

Type: Full
Date: *07/30/24*
Time: 13:00:00
Report: 1051241064
Gabby Care Homes Llc - Sam'S H

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241064 of 07/30/24.

Certified Food Protection Manager: Joy M. Morabu

Certification Number: FM110188 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Sam Obwaya
Assistant Director

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us