Electronically Delivered

November 28, 2023

Licensee
Greatercare Facilities, LLC
7159 Robinwood Trail
Woodbury, MN 55125

RE: Project Number(s) SL34002015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 the 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://www.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 me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34002	A. BUILDING: _____ B. WING _____	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	7159 ROBINWOOD TRAIL WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL34002015-0 On October 23, 2023, to October 24, 2023, 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) residents, all of whom received services under the provider's Assisted Living license.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 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 October 23, 2023, 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		
0 550 SS=A	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	0 550		

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0 550	Continued From page 2 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 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 contact information for the state and applicable regional Office of Ombudsman for Long-Term Care, the Office of Mental Health and Developmental Disabilities, and reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This had the potential to affect all four (4) of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 23, 2023, at 12:30 p.m., during a tour	0 550		

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0 550	Continued From page 3 of the facility with licensed assisted living director (LALD)-A, no posting of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care, the Office of Mental Health and Developmental Disabilities, and reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center was observed in the common areas of the facility. The licensed assisted living director (LALD)-A stated the required content noted above, was not posted. The licensee's Compliant/Grievance Policy dated August 1, 2021, lacked direction to post the above information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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; (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	0 640		

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0 640	Continued From page 4 by: Based on observation, interview and record review, the licensee failed to post the required content in common areas to include: 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all four (4) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 October 23, 2023, at 12:30 p.m., during a tour of the facility with licensed assisted living director (LALD)-A, no posting of the 911 emergency number was observed in common areas and near telephones provided by the assisted living facility. LALD-A stated the 911 emergency number was not posted in common areas or near telephones. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, directed the licensee post the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 640		

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0 640	Continued From page 5 (21) days	0 640		
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 observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license.	0 680		

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0 680	Continued From page 6 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 October 23, 2023, at 12:30 p.m., during a tour of the facility with licensed assisted living director (LALD)-A, the surveyor observed no signage or information posted regarding the licensee's emergency plan. On December 9, 2021, at approximately 3:00 p.m., the surveyor reviewed the licensee's emergency preparedness plan and components with licensed assisted living director (LALD)-C. LALD-C stated the licensee's emergency preparedness plan had not been completed. On October 24, 2023, at 12:55 p.m., the surveyor requested the licensee's EPP. Licensed assisted living director (LALD)-A stated she completed and reviewed the EP binder, and she was not aware of all the required content. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review of EPP; -arrangement with other facilities (including sister facilities); - policies and procedures for volunteers; - roles under a wavier declared by secretary;	0 680		

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0 680	Continued From page 7 -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that would be in alignment with facility requirements, and would also comply with Centers for Medicare and Medicaid Services (CMS) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 8 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 outside and in the immediate vicinity of all sleeping rooms throughout the facility. 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) 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). Findings include: On a facility tour on October 24, 2023, at approximately 11:45 a.m. with clinical nurse supervisor (CNS)-B it was observed that a smoke alarm was not provided and interconnected outside and in the immediate vicinity of resident sleeping room #5. Smoke alarms are required to be installed and interconnected outside and in the immediate vicinity of all sleeping rooms throughout the facility. These deficient findings were visually verified by CNS-B at the time of discovery.	0 780		

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0 780	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=D	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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 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). Findings include: On a facility tour by phone on October 24, 2023, at approximately 11:45 a.m. with clinical nurse supervisor (CNS)-B it was observed the ceiling tile near the light in resident sleeping room #5	0 800		

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0 800	Continued From page 10 was broken and falling out of place. Ceilings and ceiling tiles are required to be maintained as installed at the time of construction approval. These deficient conditions were visually verified by CNS-B accompanying on the tour. 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 11 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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). Findings include: A record review of available documentation and phone interview were conducted on October 24, 2023, at approximately 12:30 p.m. of documents provided by clinical nurse supervisor (CNS)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide room numbers identifying the resident rooms on the fire safety and evacuation floor plan but did provide them on or adjacent to the door of each resident	0 810		

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0 810	Continued From page 12 room. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors in order to provide efficient communication for exiting in the event of a fire or similar emergency. Record review of the available documentation indicated the facility included basic employee actions required in the event of a fire or similar emergency within the plan but had not updated the language to include detailed specific language for this facility. Fire safety and evacuation plans are required to be updated to include detailed specific employee actions for this facility. Record review of the available documentation indicated that the licensee did not include detailed fire protection procedures necessary in the event of a fire or similar emergency for residents of this specific facility. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. Record review of the available documentation indicated that employees did not receive training based on the fire safety and evacuation plan for the specific facility. Training of employees is required at hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures of this facility. Employee training based on the facility fire safety and evacuation	0 810		

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	34002	A. BUILDING: _____ B. WING _____	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	7159 ROBINWOOD TRAIL WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 plan is required to be completed and documented separately from drills. Record review of the available documentation indicated that the facility did not offer specific training based on the facility fire safety and evacuation plan to the residents. Resident training based on the facility fire safety and evacuation plan is required to offered to the residents at least annually. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence. Documentation for 2 fire drills were provided in February and October 2023. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from employee training records. All deficiencies were verified by CNS-B during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment;	01370		

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01370	Continued From page 14 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-C to include all required content. 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	01370		

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01370	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired on September 28, 2022, to provide direct services to the residents of the facility. On October 24, 2023, at 8:07 a.m., surveyor observed while ULP-C prepared to check R1's temperature, pulse, and oxygen saturation level. ULP-C gathered the thermometer and pulse oximeter. Surveyor observed ULP-C obtain R1's temperature, pulse, and oximeter saturation level. ULP-C was observed informing clinical nurse supervisor (CNS)-B of R1's abnormal pulse of 52. ULP-C documented the results in R1's medical record. On October 24, 2023, at 8:10 a.m., surveyor observed ULP-B prepare and administer oral medications to R1. ULP-C's employee record lacked documentation of training and competency evaluations for the following: - 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; (iv) dressing and assisting with toileting; - standby assistance techniques and how to	01370		

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01370	Continued From page 16 perform them; - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported. On October 24, 2023, at 10:20 a.m., licensed assisted living director (LALD)-A stated ULP-C had not completed training or competency testing on the requirements listed above. LALD-A further stated she was unaware that competencies were required if employees completed EduCare courses. The licensee's Competency Training Evaluations policy, dated August 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP was trained in the proper methods to perform the tasks or procedures for each resident and were able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who were determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP would include: 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; - standby assistance techniques and how to perform them; - awareness of commonly used health technology	01370		

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01370	Continued From page 17 equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported; - training on reading and recording temperature, pulse, and respirations of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of two employees (clinical nurse supervisor (CNS)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01460		

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01460	Continued From page 18 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: CNS-B was hired on July 18, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-B's employee records lacked evidence the employee received orientation to include the following topics: - an overview of Assisted Living Laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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	01460		

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01460	Continued From page 19 other relevant advocacy services - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On October 24, 2023, at 10:09 a.m., licensed assisted living director (LALD)-A stated CNS-B's employee record lacked documentation of the above noted required training. LALD-A further stated licensee was not aware of this requirement. The licensee's Orientation of Staff and Supervisors policy dated August 1, 2021, indicated the orientation must include the above noted required training. The policy also indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the	01490		

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01490	Continued From page 20 required hours of dementia care training for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: CNS-B CNS-B was hired on July 18, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-B's employee record lacked at least eight hours of initial dementia training within 120 working hours of the employment start date including: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. ULP-C ULP-C was hired on September 28, 2022, to provide direct services to the residents. ULP-C's employee record lacked at least eight hours of initial dementia training within 160 working hours of the employment start date including: (1) an explanation of Alzheimer's disease and	01490		

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01490	Continued From page 21 other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On October 24, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated CNS-B and ULP-C had not completed the required dementia training. LALD-A further stated the licensee assigned EduCare courses to their employees, and stated dementia courses were not yet assigned to all employees. The licensee's Dementia Training policy, dated August 1, 2021, indicated All staff of Greater Care Facilities LLC would be required to complete dementia training at the time of hire and annually thereafter. Furthermore, supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date, and direct care employees would complete eight (8) hours of dementia training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
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	01530		

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01530	Continued From page 22 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 employees received the required hours of dementia care training for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01530		

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01530	Continued From page 23 CNS-B CNS-B was hired on July 18, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. The employment records of CNS-B lacked documentation of the required eight hours of initial dementia care training within 120 working hours of the employment start date, and at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. ULP-C ULP-C was hired on September 28, 2022, to provide direct services to the residents. The employment records of ULP-C lacked documentation of the required eight hours of initial dementia care training within 160 working hours of the employment start date, and at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On October 24, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A confirmed CNS-B and ULP-C had not completed the required dementia training. LALD-A further stated the licensee assigned EduCare courses to their employees, and confirmed dementia courses were not yet assigned to all employees. The licensee's Dementia Training policy, dated August 1, 2021, indicated All staff of Greater Care Facilities LLC would be required to complete dementia training at the time of hire and annually thereafter. Furthermore, supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start	01530		

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01530	Continued From page 24 date, and direct care employees would complete eight (8) hours of dementia training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
03090 SS=A	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all four (4) residents residing in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03090		

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03090	Continued From page 25 The finding include: On October 23, 2023, at 11:00 a.m. upon arriving at the establishment, the outside front entrance and just inside the front entrance were observed to lack the required signage posted with the required verbiage regarding electronic monitoring. On October 23, 2023, at 12:30 p.m. the licensed assisted living director (LALD)-A verified there was signage posted indicating electronic monitoring at facility entrances, but it did not include the required verbiage regarding electronic monitoring. LALD-A stated she was not aware of the verbiage requirement. The licensee's Electronic Monitoring policy, dated August 1, 2021, directed signs be installed at each facility entrance with the required verbiage regarding electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *10/23/23*
Time: 11:00:00
Report: 1031231296

Food and Beverage Establishment Inspection Report

Location:
Greatercare Facilities Llc
7159 Robinwood Trail
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0038276
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513431472
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.

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

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

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

1. SHELL EGGS STORED ON TOP SHELF ABOVE MILK.
2. RAW PORK STORED NEXT TO BREAD AND FRUIT.

HAD STAFF MOVE RAW ITEMS TO BOTTOM DRAWER OF REFRIGERATOR 1. KEEP RAW MEATS STORED BELOW ALL READY-TO-EAT FOODS.

Comply By: 10/23/23

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 10/26/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 10/26/23

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

CONVECTION OVEN INTERIOR FOUND WITH ENCRUSTED SPLATTERS THROUGHOUT CAVITY AND ON GLASS. CLEAN OVEN.

Comply By: 11/06/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN SHELVES AND REPLACE CONTACT PAPER IN FOOD CUPBOARD IN KITCHEN.

Comply By: 11/06/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Butter
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator 1
Violation Issued: No

Process/Item: Cold Hold/Deli Meat
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator 2
Violation Issued: No

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

NOTES:
- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Make sure to datemark any TCS items that are kept in refrigerator.
- Staff should be washing hands in left kitchen sink basin. every time they prepare foods in kitchen.
- Ensure there is soap and paper towels to the left of the left hand sink basin for handwashing.
- Current garbage can to be replaced with a foot petal style can.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.
- Always store raw foods on the lowest refrigerator shelf.

Type: Full
Date: *10/23/23*
Time: 11:00:00
Report: 1031231296
Greatercare Facilities Llc

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 Environmental Health inspection report number 1031231296 of 10/23/23.

Certified Food Protection Manager: Miriam A Egbudom

Certification Number: FM114565 Expires: 12/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Miriam A Egbudom
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231296

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 10/23/23
Time In 11:00:00
Time Out

Greatercare Facilities Llc	Address: 7159 Robinwood Trail	City/State: Woodbury, MN	Zip Code: 55125	Telephone: 6513431472
License/Permit #: 0038276	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 11/01/23

Inspector (Signature)