Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

August 16, 2024

Licensee
Grace Assisted Living LLC
824 Pleasant Avenue
St Paul Park, MN 55071

RE: Initial License Number 412303
Health Facility Identification Number (HFID) 40060
Project Number(s) SL40060015

Dear Licensee:

On July 24, 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 May 31, 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 August 16, 2024.

The Department of Health concludes the licensee is in substantial compliance. 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.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 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 May 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:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on July 24, 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, no immediate fines are assessed.

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).

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

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,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40060	A. BUILDING: _____ B. WING _____	R 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	824 PLEASANT AVENUE ST PAUL PARK, MN 55071

(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: SL40060015-1 On July 24, 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 May 31, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued: 2310.	{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.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	{0 480}		

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the	{0 620}		

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{0 620}	Continued From page 3 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action required.	{0 620}		
{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	{0 800}		

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{0 800}	Continued From page 4 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: No further action required.	{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. (f) Evacuation drills are required for employees	{0 810}		

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{0 810}	Continued From page 5 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{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	{0 950}		

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{0 950}	Continued From page 6 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: No further action required.	{0 950}		
{01370} SS=E	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; (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	{01370}		

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{01370}	Continued From page 7 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: No further action required.	{01370}		
{01620} SS=D	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 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	{01620}		

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{01620}	Continued From page 8 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: No further action required.	{01620}		
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of two residents (R2) with a bed rail. 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: On July 24, 2024, at 11:05 a.m. R2's room was	{02310}		

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{02310}	Continued From page 9 observed to have a bed with bilateral hospital bed rails in the raised position. Unlicensed personnel (ULP)-C stated R2 received the bed recently as needed more assistance with transfers and bed mobility. R2's diagnoses included hypertension (high blood pressure). R2's Service Plan dated July 10, 2024, indicated R2 received services including medication administration, blood pressure monitoring, housekeeping, laundry, toileting reminders, and assistance with bathing, dressing, and grooming. R2's assessment dated July 12, 2024, did not include measurements of the bed rail zones of entrapment. On July 24, 2024, at 12:41 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated she had assessed R2's bedrails on July 12, 2024, though didn't include the measurements as was unsure how to record the zones. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH)	{02310}		

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{02310}	Continued From page 10 website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided.	{02310}		

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{02310}	Continued From page 11 The licensee's Side Rail Use policy dated July 21, 2022, indicated: 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. No further information was provided.	{02310}		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: No further action required.	{02320}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

July 1, 2024

Licensee
Grace Assisted Living LLC
824 Pleasant Avenue
St Paul Park, MN 55071

RE: Provisional Conditional License Number 412303
Health Facility Identification Number (HFID) 40060
Project Number(s) SL40060015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 31, 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.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **August 30, 2024**.

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 $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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 Grace Assisted Living LLC a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 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 Grace Assisted Living LLC is in substantial

compliance.

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

a. **No new admissions:** Grace Assisted Living LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Grace Assisted Living LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Grace Assisted Living LLC 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

b. **Locks:** Grace Assisted Living, LLC, will correct the key-only clasp lock and sliding chain lock on the front door, key-only lock on back door and key-only lock on deck gate:

    i. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in event of an emergency.
    ii. When locked doors or exterior gates are installed as part of the egress path, these doors and gates must interconnect with the fire safety systems and must default to an unlocked exiting under activation of the fire alarm, fire sprinklers or a loss of power.
    iii. Door locking hardware must release in a single operation and is required to be located not higher than 48" from the floor.

c. **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 provisional license. If MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Grace Assisted Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Grace Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Grace

Assisted Living LLC. If MDH determines Grace Assisted Living LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40060	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	824 PLEASANT AVENUE ST PAUL PARK, MN 55071

(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: SL40060015 On May 28, 2024, through May 31, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's provisional Assisted Living license. 2310: The immediacy was removed May 29, 2024, scope and level of noncompliance remained at level 3/Widespread (I).	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the staff posting included all the required elements, potentially affecting all 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	0 470		

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0 470	Continued From page 2 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 included: On May 28, 2024, at 1:02 p.m. the surveyor reviewed postings above the desk in the living room area. The posted staff schedule was dated May 13, 2024, thru May 26, 2024. On May 29, 2024, at approximately 2:00 p.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed the posted staff schedule and stated it was not current. The licensee's Assisted Living Staffing Plan, reviewed January 2, 2024, indicated: Schedule will be posted in a central location in each building so that is accessible to staff; residents; volunteers and the public. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480		

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0 480	Continued From page 3 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 May 29, 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		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the	0 620		

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0 620	Continued From page 4 common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The	0 620		

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0 620	Continued From page 5 lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) who eloped from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 28, 2024, at 2:08 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated vulnerable adult reporting should occur immediately but not exceed 24 hours. R1's diagnoses included cerebral vascular accident (stroke), acquired immune deficiency syndrome (AIDS), congestive heart failure (CHF), sacral pressure ulcer, and breathing problems. R1's Service Plan printed May 28, 2024, indicated R1 received services including medication administration, wound care, repositioning, bathing, grooming, dressing, transfers, incontinence care, housekeeping, and laundry.	0 620		

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0 620	Continued From page 6 R1's RN assessment dated March 7, 2024, indicated R1 needed full assistance with bathing, dressing, transfers, and was unable to walk but utilized a power chair independently. R1's MAARC report submitted March 4, 2024, indicated R1 had left the residence around 6:00 p.m. on March 1, 2024, and still had not returned to the house. R1 had been gone for three days before the MAARC report was submitted. R1's progress note dated April 14, 2024, at 9:50 p.m. indicated R1 had left the house for an appointment around 8:00 a.m. and hadn't returned home yet. R1's progress note dated April 19, 2024, at 7:13 p.m. indicted R1 still hadn't returned home. The Saint Paul Park Police Department had been notified. R1's progress note dated May 2, 2024, at 6:46 p.m. indicated R1 had returned home today May 2, 2024, around 6:30 p.m. Transported by the HCMC (Hennepin County Medical Center) ambulance. R1 had been missing for 18 days. R1's record did not include evidence a MAARC report had been submitted. On May 29, 2024, at 1:27 p.m. LALD/RN-A stated unlicensed personnel (ULP)-B was responsible for filing MAARC reports. LALD/RN-A further stated with R1's last elopement, ULP-B probably just called law enforcement rather than filling out a MAARC report. On May 29, 2024, at 1:54 p.m. ULP-B stated he	0 620		

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0 620	Continued From page 7 had not filed a MAARC report when R1 eloped on April 14, 2024; although, did notify the police. The licensee's Vulnerable Adult Maltreatment Policy dated July 21, 2022, indicated: 2. The assisted living employee has responsibility for the following: f. When abuse or neglect directed toward a vulnerable adult is discovered, the employee is to report the incident in the following manner: 1) Internal Reporting - The employee may make an oral report immediately by phone or otherwise to the director or clinical nurse supervisor - The employee shall be instructed to complete a written report of the abuse and/or neglect within 24 hours. - The clinical nurse supervisor or director will review the situation and investigate to determine if this is a reportable incident, and if so, the information will then be reported/submitted to the MAARC immediately or as soon as possible. - A copy of the report will be sent to the MAARC and a copy will be retained in the clinical record. 3) External Reporting: Any employee may report directly to the MAARC if he/she does not want to report internally. The external report shall be complete/submitted immediately or as soon as possible. The oral report must be followed by a written report. A copy of the written report will be given to the director. The licensee will not retaliate against any employee who reports externally. The licensee's Missing Resident policy dated July 21, 2022, indicated: The licensee will immediately investigate any missing resident using an organized approach in order to ensure that if a resident is found to be	0 620		

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0 620	Continued From page 8 missing, the appropriate authorities are notified. 8. A vulnerable adult report (MAARC) will be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 provide the physical environment in a continuous state of good repair and operation with regard to 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 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).	0 800		

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0 800	Continued From page 9 The findings include: On May 28, 2024, at 1:15 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: 1. The door leading into the attached garage from the home was labeled as an exit on the emergency floor plan dated April 2, 2023. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During an interview on May 31, 2024, at 8:00 a.m., LALD/RN-A verified the door leading into the attached garage was improperly labeled as an exit on the floor plan. 2. Three rows of siding were missing, and several rows of siding were noted as loose on the exterior of the home. Siding must be properly installed and maintained to protect the home from natural elements. During the tour interview on May 28, 2024, LALD/RN-A verified the missing and loose siding. 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	0 810		

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0 810	Continued From page 10 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide required 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40060	A. BUILDING: _____ B. WING _____	05/31/2024

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0 810	Continued From page 11 or has potential to affect a large portion or all of the residents). The findings include: On May 30, 2024, the licensed assisted living director/registered nurse (LALD/RN)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a 9.06 Fire Safety Policy dated August 1, 2021. The fire safety policy was a template and had not been developed for the facility location. This policy inappropriately referenced smoke compartment doors, fire doors on magnetic holders, and fire sprinklers. The fire safety policy 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 employee actions were limited to the RACE acronym (Remove, Alarm, Confine, and Evacuate). The FSEP did not identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.	0 810		

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0 810	Continued From page 12 During an interview on May 31, 2024, at 8:00 a.m., LALD/RN-A verified the fire safety policy included inaccurate information, the FSEP lacked required content, and the FSEP needed revision. DRILLS Record review indicated the licensee failed to maintain fire drill documentation evident by fire drill reports lacking required information. The names of the employees who had participated in the drills were not recorded. During an interview on May 31, 2024, at 8:00 a.m., LALD/RN-A verified the licensee had not recorded employee names on the fire drill logs. LALD/RN-A stated this information would be included in future fire drill records. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	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.	0 820		

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0 820	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees. 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 May 28, 2024, at 1:15 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: 1. The front door was locked and required a key to open it during the facility tour. A key only clasp lock and a sliding chain lock were installed near the top of the front door. The front door had an exit sign posted and was labeled as an exit on the emergency floor plan dated April 2, 2023. 2. The dining room back door was locked and required a key to open it during the facility tour, a key only clasp lock was installed near the top of this door. During the facility tour interview on May 28, 2024, LALD/RN-A stated the back door was kept locked and staff had keys to open this door. The back door had an exit sign posted and was labeled as an exit on the emergency floor plan dated April 2, 2023. When the dining room back	0 820		

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0 820	Continued From page 14 door was opened it led out to a deck. A key only lock was installed on the deck gate. LALD/RN-A demonstrated the gate was not locked during the tour and stated this gate lock was not used. All paths of egress must provide unobstructed exiting. The use of locking hardware requiring a key would limit the ability of occupants to safely evacuate in the event of an emergency. Door locking hardware must release in a single operation and is required to be located not higher than 48" from the floor. During the tour interview on May 28, 2024, LALD/RN-A verified the installation of these locks and stated the locks had been installed because all the current residents were dementia care. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
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	0 950		

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0 950	Continued From page 15 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 ensure the assisted living contract included the designation of representative statutory language for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Resident Agreement (contract) was signed August 25, 2023. R1's contract and record lacked the following required content:	0 950		

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0 950	Continued From page 16 - 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." On May 29, 2024, at approximately 2:00 p.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's contract and record, and stated it lacked the required verbatim content as listed above. LALD/RN-A further stated the licensee's contract would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=E	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;	01370		

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01370	Continued From page 17 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP)	01370		

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01370	Continued From page 18 providing assisted living services were conducted by a registered nurse (RN) for two of two unlicensed personnel (ULP-B and 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 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: ULP-B ULP-B began providing direct care services for the licensee on October 10, 2023. ULP-B's employee record lacked evidence the employee had been trained by a RN 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 -dressing and assisting with toileting - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family ULP-C ULP-C began providing direct care services for the licensee on October 16, 2023.	01370		

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	40060	A. BUILDING: _____ B. WING _____	05/31/2024

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01370	Continued From page 19 ULP-C's employee record lacked evidence the employee had been trained by a RN 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 -dressing and assisting with toileting - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family - understanding appropriate boundaries between staff and clients and the client's family On May 29, 2024, at 4:38 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B and ULP-C's records did not include the above required training. The licensee's 5.02 Competency Training Evaluation policy dated August 1, 2021, indicated: 4. Training and competency evaluations of ULPs will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. 5. Training an competency evaluations for all ULPs will included: e) 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 k) 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	01370		

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01370	Continued From page 20 m) Understanding appropriate boundaries between staff and residents and the resident's family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01620 SS=D	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 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:	01620		

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	40060	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	824 PLEASANT AVENUE ST PAUL PARK, MN 55071

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01620	Continued From page 21 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a timely comprehensive change of condition assessment following hospitalization for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included cerebral vascular accident (stroke), acquired immune deficiency syndrome (AIDS), congestive heart failure (CHF), sacral pressure ulcer, and breathing problems. R1's Service Plan printed May 28, 2024, indicated R1 received services including medication administration, wound care, repositioning, bathing, grooming, dressing, transfers, incontinence care, housekeeping, and laundry. R1's progress note dated May 21, 2024, indicated R1 had gone to a medical appointment and was subsequently hospitalized. R1's progress note dated May 23, 2024, indicated R1 had been discharged from the hospital and returned to the residence around 7:30 p.m. R1's hospital After Visit Summary dated May 21, 2024, - May 23, 2024, indicated R1 was hospitalized for a skin infection on his back;	01620		

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01620	Continued From page 22 discharge orders included medication changes and wound care treatment. R1's RN assessment following return from the hospital was dated May 28, 2024 (five days later). On May 29, 2024, at 1:27 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated having access to R1's discharge orders and ensured medication changes were made remotely. LALD/RN-A further stated she tried to complete the post hospitalization assessments on the day of return from the hospital but had not come to the facility until Monday, May 28, 2024. However, LALD/RN-A did not complete R1's assessment until after the surveyor entered the residence on May 29, 2024. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated: The facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for two of two residents (R1, R2) with a bed rail. This resulted in an immediate correction order on May 28, 2024, at 2:25 p.m. 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: R1 On May 28, 2024, during the environmental tour at approximately 1:30 p.m., R1's room was observed to have a bed with bilateral hospital bed rails. R1 was lying in the bed watching television; the bedrail next to the wall was in the raised position. R1's diagnoses included cerebral vascular accident (stroke). R1's Service Plan printed May 28, 2024, indicated R1 received services including medication administration, wound care, repositioning, bathing, grooming, dressing, transfers, incontinence care, housekeeping, and laundry. R1's Bed Safety Assessment dated March 7,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 24 2024, indicated R1 had an electric bed with a mattress original to bed; specialty mattress from hospital. The assessment further indicated the bed rails did not function as a restraint. R1's record lacked: - measurements of the bed rail zones of entrapment; and - documentation of risks vs. benefits being discussed with R1 or R1's responsible party. R2 On May 28, 2024, during the environmental tour at approximately 1:25 p.m., R2's room was observed to have a bed with an upside-down U-shaped assist bar at the head of the bed on the exit side by the window. R2's diagnoses included hypertension (high blood pressure). R2's Service Plan printed May 28, 2024, indicated R2 received services including medication administration, blood pressure monitoring, housekeeping, laundry, toileting reminders, and assistance with bathing, dressing, and grooming, R2's record lacked: - an assessment for bed rail use; - documentation of risk vs. benefits discussion with R2 or R2's responsible party; - documentation R2's bed rail was used, installed, and maintained per manufacturer's instructions; and - documentation R2's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). During the entrance conference on May 28, 2024, at 2:25 p.m., licensed assisted living director	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40060	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	824 PLEASANT AVENUE ST PAUL PARK, MN 55071

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02310	Continued From page 25 /registered nurse (LALD/RN)-A stated R2 had purchased her own bed assist rail for the bed and was not aware she needed to assess it for safety. LALD/RN-A further stated for R1's hospital bed rails, the licensee made sure the rails would not cause entrapment but was not sure that was documented anywhere. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large	02310		

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	40060	A. BUILDING: _____ B. WING _____	05/31/2024

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02310	Continued From page 26 enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The MDH website also indicated for consumer bed rails, the licensee should refer to the CPSC for the most up-to-date information related to portable bed rail recall information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On May 29, 2024, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I.	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained	02320		

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	40060	A. BUILDING: _____ B. WING _____	05/31/2024

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02320	Continued From page 27 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of two residents (R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included cerebral vascular accident (stroke), acquired immune deficiency syndrome (AIDS), congestive heart failure (CHF), sacral pressure ulcer, and breathing problems. R1's Service Plan printed May 28, 2024, indicated R1 received services including medication administration. R1's medication administration record (MAR) dated May 2024, included an order for Dulera 100-5 mcg (microgram) inhaler. Inhale two puffs into the lungs twice a day, and buprenorphine/naloxone (schedule III for opioid use disorder) 8-2 mg (milligram) sublingual tablet. Dissolve one tablet under tongue three times a	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40060	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 28 day. On May 29, 2024, at 8:58 a.m. unlicensed personnel (ULP)-B was observed setting up and administering medications to R1. ULP-B set-up all R1's scheduled oral medications except the buprenorphine/naloxone, into one medication cup; the buprenorphine/naloxone was placed in a separate medication cup. Upon entering R1's room, ULP-B first handed the cup with the majority of R1's oral medications to R1, who then consumed the medication with water. ULP-B then handed R1 his Dulera inhaler and the resident administered independently. ULP-B then handed R1 the medication cup containing the buprenorphine/naloxone medication, asked the resident if he was "good", then exited the room without observing R1 consume the medication. In addition, ULP-B did not prompt R1 to rinse his mouth with water and spit after administering the inhaler and prior to taking the buprenorphine/naloxone. On May 29, 2024, at 2:16 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated would expect staff to prompt R1 to rinse mouth after inhaler use and further stated this was part of the competency testing. At 4:12 p.m., LALD/RN-A sated she would expect ULP to stay and watch residents take all medications before leaving the room. The manufacturer's Dulera Patient Information package insert indicated: After each dose (2 puffs) of DULERA, rinse your mouth with water. Spit out the water. Do not swallow it. This will help to lessen the chance of getting a yeast infection (thrush) in the mouth and throat.	02320		

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02320	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *05/29/24*
Time: 12:00:00
Report: 1005241112

Food and Beverage Establishment Inspection Report

Location:
Grace Assisted Living LLC
824 Pleasant Avenue
St Paul Park, MN55071
Washington County, 82

Establishment Info:
ID #: 0041115
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

AFTER INSPECTION, OPERATOR SENT INSPECTOR A PICTURE OF A THERMOLABEL THAT THEY RAN THROUGH THEIR DISHWASHER THAT REACHED A TEMPERATURE OF ONLY 150 DEGREES F. ADJUST, REPAIR, OR REPLACE DISHWASHER.

Comply By: 05/29/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED TCS FOODS, INCLUDING MILK AND DELI MEAT, WERE NOT DATE MARKED. MARK THE DATES THAT TCS FOODS ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET EMAILED WITH REPORT.

Comply By: 05/29/24

Type: Full
Date: *05/29/24*
Time: 12:00:00
Report: 1005241112
Grace Assisted Living LLC

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE.

Comply By: 06/05/24

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.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 06/05/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/HAM
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR, WENDY BUCKHOLZ.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

THERMOLABELS WERE LEFT ON SITE AND OPERATOR LATER SENT A PICTURE OF THE LABEL THAT WAS RUN THROUGH THE DISHWASHER, WHICH ACHIEVED A UTENSIL SURFACE TEMPERATURE OF ONLY 150 DEGREES F. DISHES MUST BE SANITIZED IN A CHEMICAL SANITIZER (50-100 PPM CHLORINE, FOR EXAMPLE) UNTIL DISHWASHER IS

PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241112 of 05/29/24.

Certified Food Protection Manager: LESLIE A. HUNA

Certification Number: FM108954 Expires: 12/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

LESLIE HUNA
FOOD MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us