Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

September 29, 2025

Licensee
Graceland Home Services LLC
417 1st Street Northwest
Saint Michael, MN 55376

RE: Denial of License Number 417505
Health Facility Identification Number (HFID) 41060
Initial survey; Project Number(s) SL41060015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on August 29, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

STATE CORRECTION ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Kelly Thorson, via email at: Kelly.Thorson@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than October 2, 2025.**

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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.

If you have any additional questions, please do not hesitate to contact Kelly Thorson, Supervisor, at Kelly.Thorson@state.mn.us. Kelly Thorson can also be reached by office phone at 320-223-7336.

Sincerely,

Rick Michals

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
	41060	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND HOME SERVICES LLC	417 1ST STREET NORTHWEST SAINT MICHAEL, MN 55376

(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: SL41060016-0 On August 26, 2025, through August 28, 2025, the Minnesota Department of Health conducted a initial survey at the above provider and the following correction orders are issued. At the time of the survey, there was 1 resident; 1 receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on August 26, 2025, issued for SL41060016-0, tag identification 0470. During the survey, the licensee took action to mitigate the immediate risk. However; the scope and level remain unchanged.	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 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/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 the potential to affect a large portion or all the residents). The findings include: On August 25, 2025, at 9:17 a.m. the Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed. The BELTSS website LALD held a current LALD license (issued November 1, 2018). The website did not list LALD as the Director of Record for the licensee. On August 25, 2025, at 9:35 a.m. agent (A)-B stated that they were aware LALD was not listed under the licensee and stated that they were in the process getting LALD listed.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 3 Based on observation, interview and record review, the licensee failed to ensure they had one or more persons available 24 hours per day, seven days per week, who were awake and responsible for responding to the requests of residents for assistance with health or safety needs. Additionally, licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 25, 2025, at 10:02 a.m., agent (A)-B stated licensee did not have a staffing plan as they were not aware a staffing plan was required. A-B stated that if there was a need for staffing A-B would step in the role to assist with meeting the needs of the licensee's residents. A-B stated that there was one to two unlicensed personnel (ULP) on the first 12-hour shift with the second ULP being trained into their role; and one ULP on the second 12-hour shift. A-B stated the first 12-hour shift started at 7:00 a.m. to 7:00 p.m. and second 12-hour shift from 7:00 p.m. to 7:00 a.m. On August 26, 2025, at 8:55 a.m., upon resident	0 470		

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0 470	Continued From page 4 interview with R1; R1 stated "staff are sleeping here I do not go and see but I think so. I think they sleep on the couch in the living room." On August 26, 2025, at 9:01 a.m., ULP-A stated "I do the overnight and I am right in the living room and I do the safety check twice a night and yes I sleep at night and R1 has their call light if R1 needs something where I can assist R1 and I set my alarm to wake up and do R1's two safety checks at night." ULP-A stated they were not aware they could not sleep on the overnight shift. The licensee's 6.15 Staffing Requirements-Licensed Nurse and ULP policy dated December 7, 2024, indicated persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standard appropriate to the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480		

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0 480	Continued From page 5 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 6 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 August 25, 2025, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 7 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), which included completion of aTB facility risk assessment and failed to complete an employee TB symptom and history screen for one of one employee (unlicensed personnel (ULP)-A) 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: During the entrance conference on August 25, 2025, at 9:15 a.m., agent (A)-B stated the licensee was familiar with current minimum assisted living requirements. During the entrance	0 660		

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0 660	Continued From page 8 conference surveyor requested for the licensee's TB facility risk assessment with A-B stating that the form was in the licensee's policy book. On August 25, 2025, at 12:10 p.m. unlicensed personnel (ULP)-A provided the licensee's policy book with ULP-A and surveyor unable to find the TB risk assessment. ULP-A was hired November 6, 2024, to provide direct care for residents of the facility. ULP-A's employee record included documentation of a negative TB blood test dated October 21, 2024, but lacked documentation of a TB history and symptom screening form. On August 25, 2025, at 12:11 p.m. ULP-A stated she was not aware a TB screen was performed at licensee and was unable to locate the documentation of a TB history and symptom screen. On August 28, 2025, at 12:30 p.m., A-B stated they were aware of the requirement for the facility risk assessment and TB history and symptom screen and would complete each item moving forward. The licensee's TB Prevention and Control policy dated August 7, 2022, indicated a community TB risk assessment will be completed annually. The MDH guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated August 28, 2025, and based on CDC guidelines, indicated a facility TB risk assessment should be completed initially and on an annual basis. The MDH Assisted Living Resources and	0 660		

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0 660	Continued From page 9 Frequently Asked Questions (FAQs) last updated August 28, 2025, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease and assessing TB history. The licensee's 8.16 Tuberculosis Screening policy dated December 8, 2024, read "the facility will maintain a current community TB risk assessment. Staff will be screened for TB using the baseline TB screening tool." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (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	0 680		

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0 680	Continued From page 10 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 develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and post in a prominent location. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of 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 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: During the entrance conference on August 25, 2025, at 1:15 p.m., Agent (A)-B stated the licensee was familiar with the current minimum assisted living requirements. During facility tour on August 25, 2025, at 9:22 a.m. surveyor observed no postage for the EPP. Unlicensed personnel (ULP)-A stated the EPP was in a locked cabinet in the kitchen. ULP-A and	0 680		

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0 680	Continued From page 11 A-B stated they were not aware the EPP was required to be posted in the prominent location. A-B stated the EPP was located within the licensee's policy binder. The emergency disaster preparedness plan dated 2024, lacked evidence of the following required content: -documentation of the date of review and any updates made to the plan based on the review; -program patient population; -documentation of the date of review and any updates made to the EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; -documentation identifying at risk population needs like maintaining independence, communication, transportation, supervision and medical care; -process for EP collaboration; -subsistence needs for staff and residents; -procedures for tracking of staff and residents; -policies and procedures for medical documents; - policies for volunteers; -arrangement with other facilities; -roles under a waiver declared by secretary; -development of a communication plan; -communication plan; -conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP; -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 table-top exercise; -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed; and -develop/implement EP policies and procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies -Alternate sources of energy to maintain: -Temperatures to protect resident health/safety -Safe/sanitary storage of provisions -Emergency lighting -Fire detection, extinguishing, alarm systems -Sewage and waste disposal. On August 25, 2025, at 12:18 p.m., surveyor reviewed the missing policy dated November 15, 2024, ULP-A and A-B were not aware the missing resident policy was required to be reviewed on a quarterly basis. The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance indicated the emergency preparedness plan would include all required elements of appendix Z and would be reviewed annually. The licensee's 2.28 Missing Resident Policy dated November 15, 2024, indicated licensee would review the policy at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 13 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers.	0 790		

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0 790	Continued From page 14 This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: On August 27, 2025, from 10:15 a.m. to 11:30 a.m., the surveyor toured the facility with agent (A)-B. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. These deficient conditions were visually verified at the time of discovery by A-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 15 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more	0 810		

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0 810	Continued From page 16 than minimal harm to the resident) 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 June 4, 2024, agent (A)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 9.06 Fire Safety, dated December 8, 2024, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency	0 810		

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0 810	Continued From page 17 including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On August 27, 2025, at 1:30 p.m., A-B stated they didn't understand that the third-party policy they were using was not correct. A-B stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. A-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated training was done for one staff member on November 5, 2024, as part of an orientation training. No other training documentation was provided. On August 27, 2025, at 1:30 p.m., A-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills	0 810		

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0 810	Continued From page 18 for employees twice per year, per shift with at least one evacuation drill every other month. The licensee lacked documentation on evacuation drills onsite at the time of the survey. A-B stated they had them offsite and would email them to the surveyor by the end of the day. No email was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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	0 970		

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0 970	Continued From page 19 the residents). The findings include: On August 25, 2025, at 11:08 a.m., unlicensed personnel (ULP)-A provided licensee's resident's Assisted Living Contract for R1 and stated the contract is used by licensee for all residents who would live in the facility. The licensee's Contract Agreement dated October 16, 2024, number 15, included a section titled Liability, "The landlord is not responsible or liable for any loss, claim, damage, or expense as a result of any accident, injury, or damage to any person or property." On August 28, 2025, at 12:42 p.m., agent (A)-B acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. A-B stated licensee did not realize there was a liability waiver in the contract and would need to be removed from the licensee contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being	01440		

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01440	Continued From page 20 performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-A). 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: ULP-A was hired on November 6, 2024, to	01440		

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01440	Continued From page 21 provide assisted living services to residents. On August 25, 2025, 11:02 a.m., surveyor observed ULP-A assist R1 with a transfer belt from the dining table to the bathroom. ULP-A stated they completed R1's catheter care and was unable to place TED stockings on R1 as the stockings were damp. On August 25, 2025, at 11:38 a.m. surveyor reviewed ULP-A's employee record. ULPA's employee record lacked a 30-day supervision. On August 27, 2025, at 8:23 a.m., registered nurse (RN)-C stated, they were not aware a 30-day supervisory visit was required and would complete a 30-day supervisory visit moving forward. The licensee's 6.17 Supervision of Staff-Delegated Services dated December 7, 2024, indicated direct supervision of staff performing delegated tasks would be provided within 30 calendar days after the date on which the individual begins working for licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the	01610		

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01610	Continued From page 22 physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an ongoing 14-day and 90-day assessment utilizing the uniform assessment tool 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 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 was admitted November 6, 2024, to receive assisted living services. R1's diagnosis included hypertension (high blood pressure), overflow of incontinence and TIA (temporary interruption of blood flow to the brain).	01610		

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01610	Continued From page 23 R1's service plan dated November 6, 2024, indicated R1 received assistance medications administration, treatments, bathing assistance, grooming/hygiene assistance, dressing assistance, toileting incontinence assistance, personal laundry, housekeeping, linens, mobility, socialization, making appointments, and shopping. R1's contract signed on November 6, 2024, indicated an occupancy date of November 6, 2024. R1's record contained an admission assessment dated November 6, 2024, utilizing the uniform assessment tool. R1's ongoing assessment from the past three assessments included a Nurse Weekly Visit form dated July 21, 2025; July 11, 2025; and June 11, 2025. R1's assessments lacked a uniform assessment (4659.0150) to include the following: -the resident's personal lifestyle preferences; -activities of daily living; -instrumental activities of daily living; -physical health status; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -pain; -skin conditions; -nutritional and hydrations status; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators;	01610		

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01610	Continued From page 24 -who has decision-making authority fir resident; and -the need fir follow-up referrals fir additional medical cognitive care by the health professional. On August 27, 2025, at 8:25 a.m. registered nurse (RN)-C stated they were not aware the ongoing assessments were required to follow the uniform assessment tool. The licensee's 6.01 Assessments, reviews and Monitoring policy dated December 7, 2024, indicated assessments must include all elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 25 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of one resident (R1) receiving treatments. 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 August 25, 2025, at 9:15 a.m., unlicensed personnel (ULP)-A; agent (A)-B and registered nurse (RN)-C stated the licensee provided treatment and therapy services to residents as prescribed.	01940		

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01940	Continued From page 26 R1 was admitted on November 6, 2024, with diagnoses included hypertension (high blood pressure), overflow of incontinence and TIA (temporary interruption of blood flow to the brain). R1's service plan dated November 6, 2024, indicated R1 received assistance medications administration, treatments, bathing assistance, grooming/hygiene assistance, dressing assistance, toileting incontinence assistance, personal laundry, housekeeping, linens, mobility, socialization, making appointments, and shopping. On August 25, 2025, 11:02 a.m., surveyor observed ULP-A assist R1 with a transfer belt from the dining table to the bathroom. ULP-A stated they completed R1's catheter care and was unable to place TED stockings on R1 as the stockings were damp. R1's Medication Administration Record (MAR) dated Month: August Year:2025 indicated R1's received TED/Compression Stockings on in am and off at bedtime completed by staff August 1st through August 24th. R1's Treatment/Therapy Management Plan dated November 11, 2024, indicated resident received Compression socks. The licensee failed to develop and maintain an individualized treatment and therapy management for R1's TED/compression stockings to include: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41060	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND HOME SERVICES LLC	417 1ST STREET NORTHWEST SAINT MICHAEL, MN 55376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On August 27, 2025, at 8:26 a.m., RN-C stated they did not realize they needed to complete a more formal treatment plan to include the required content. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GRACELAND HOME SERVICES LLC
417 1ST STREET NORTHWEST
St Michael, MN 55376
Wright County
Parcel:

Phone:

License Info

License: HFID 41060

Risk:
License:
Expires on:
CFPM: Athelia B. David-Gaye
CFPM #: 53702; Exp: 10/16/2027

Inspection Info

Report Number: F1051251090
Inspection Type: Full - Single
Date: 8/25/2025 Time: 11:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT:
AT THE TIME OF INSPECTION, THERE WAS NO EMPLOYEE ILLNESS LOG. A LOG WILL BE PROVIDED WITH THE REPORT VIA EMAIL.
Comply By: 8/25/2025 Originally Issued On: 8/25/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
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.
COMMENT:
AT THE TIME OF INSPECTION, THERE WAS NO SMALL DIAMETER PROBE THERMOMETER.
Comply By: 9/1/2025 Originally Issued On: 8/25/2025

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, JESSICA DETERS.

DISCUSSED THE FOLLOWING WITH THE CARE COORDINATOR, ATHELIA:

EMPLOYEE ILLNESS LOG (LOG PROVIDED WITH REPORT VIA EMAIL)
VOMIT CLEAN-UP PROCEDURES
SMALL DIAMETER PROBE THERMOMETER

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1051251090 from 8/25/2025

Blai Yang

Athelia
Care Coordinator

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

GRACELAND HOME SERVICES LLC
St Michael
County/Group: Wright County

Inspection Info

Report Number: F1051251090
Inspection Type: Full
Date: 8/25/2025
Time: 11:30:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No