Electronically Delivered

April 3, 2025

Licensee
Door Of Grace LLC
152 102nd Lane Northeast
Blaine, MN 55434

RE: Project Number(s) SL38054016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

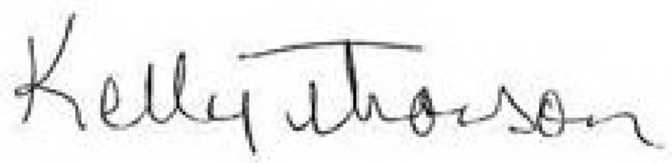
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38054	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOOR OF GRACE LLC	152 102ND LANE NE BLAINE, MN 55434

(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 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: SL38054016 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four resident(s); all receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the	0 330		

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0 330	Continued From page 1 department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide accurate and truthful information for one of one resident assessments (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 the residents). The findings include: R1 was admitted to the facility on April 25, 2023. R1's record showed an admission nursing assessment dated April 24, 2023, a 14-day assessment dated May 7, 2023, and subsequent assessments dated approximately 90 days apart with the most recent dated January 26, 2025. All but two of these assessments were signed by clinical nurse supervisor (CNS)-B. CNS-B's hire date was February 6, 2025. On March 4, 2025, at 11:15 a.m., owner/licensed	0 330		

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0 330	Continued From page 2 assisted living director (O/LALD)-A stated she has been through many registered nurses since opening the facility and was not sure what to do with the assessments that were left unsigned by previous nurses, so she asked CNS-B to sign them. On March 4, 2025, at 3:15 p.m., CNS-B stated O/LALD-A asked her to look at the past assessments and said it would be okay for her to sign them. CNS-B stated she knew it was not the right thing to do but did it anyway. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 330		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 3 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents and had a current census of four residents. On March 3, 2025, at 10:30 a.m., the surveyor reviewed the facility staffing plan and found it was developed for a different facility. On March 3, 2025, at 12:45 p.m., owner/licensed	0 470		

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0 470	Continued From page 4 assisted living director (O/LALD)-A stated the staffing plan provided was for a different facility and will look for one for this facility. On March 4, 2025, at 9:30 a.m., O/LALD-A provided the Facility Staffing Plan document that was signed by O/LALD-A on January 2, 2025. No other dates or signatures were found on this document. The plan was not evaluated by the clinical nurse supervisor. On March 4, 2025, at 11:15 a.m., O/LALD-A stated the staffing plan provided was from another facility and she did not develop it specifically for this facility and had not evaluated it twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;	0 480		

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0 480	Continued From page 5 (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. This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 6 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 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		
0 680 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;	0 680		

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0 680	Continued From page 7 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's EPP dated March 19, 2024, lacked documentation including all the required elements:	0 680		

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0 680	Continued From page 8 - missing resident plan - program patient population - process for collaboration - subsistence needs of staff and patients - procedures for tracking of staff and patients - policies and procedures including evacuation - policies and procedures for sheltering - policies and procedures for medical documents - policies and procedures for volunteers - arrangement with other facilities - roles under a waiver declared by secretary -names and contact information -methods for sharing information -sharing information on occupancy/needs - emergency prep testing requirements On March 3, 2025, at 12:50 p.m., owner/licensed assisted living director (O/LALD)-A stated she thought the EPP was complete. The licensee's undated Emergency Management policy indicated the facility will have an identified plan in place to assure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupts facility services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain access to egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 6, 2025, from approximately 10:20 a.m. to 11:55 a.m., the surveyor toured the facility with owner/licensed assisted living director (O/LALD)-A and observed the following deficient conditions: The surveyor requested that O/LALD-A open windows for measurement in resident rooms. The egress window in resident room 1 was partially obstructed by the headboard of the bed in the room. The headboard was situated in front of the window, limiting access to the openable area, which made it difficult for O/LALD-A to readily access and open the window. Egress windows must be maintained free of obstruction to allow for access in emergency evacuation. O/LALD-A stated that they understood the requirements for egress windows and instructed staff and resident that headboard should be removed from its current location immediately.	0 775		

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0 775	Continued From page 10 The ventilation of the dryer was not securely attached to the rear of the dryer, with a gap between the dryer vent and the attached plumbing. The insecure attachment of the ventilation resulted in accumulated lint behind the dryer which may contribute to risk of combustion. Dryer vent should be securely attached and accumulated lint should be removed, with area maintained free of lint. A multiplug adapter was in use in the laundry room with multiple appliances such as the washer and dryer plugged in. The surveyor explained that these appliances should not be powered utilizing a multiplug adapter as they are not rated for that amount of draw and may pose a fire hazard. The surveyor explained requirements and noted deficient conditions in the facility, as well as the importance of maintaining the facility in compliance. LALD/O-A stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 11 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 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 March 6, 2025, from approximately 10:20 a.m. to 11:55 a.m., the surveyor toured the facility with owner/licensed assisted living director (O/LALD)-A. During the tour the surveyor observed the following. The outer windowpane on the egress window assembly in resident room 4 was shattered and broken with exposed sharp glass edges. Window must be maintained in proper condition free of potentially injurious shards and sharp edges. O/LALD-A stated that the window was recently broken by a resident and confirmed this with the resident in the presence of the surveyor. O/LALD-A reported that efforts to restore window to proper safe condition were in progress. During the facility tour interview on March 6, 2025, O/LALD-A verified the above listed physical	0 800		

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0 800	Continued From page 12 environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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.	0 810		

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	38054	A. BUILDING: _____ B. WING _____	03/06/2025

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0 810	Continued From page 13 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 required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 6, 2025, at approximately 11:30 a.m., owner/licensed assisted living director (O/LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility The licensee FSEP failed to include the following: The FSEP did not include fire procedures for residents. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year.	0 810		

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0 810	Continued From page 14 During the record review and interview on March 6, 2025, O/LALD-A verified the above listed documents were absent from the FSEP. O/LALD-A stated that they understood requirements and would develop resident fire procedures for residents and implement and record trainings with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 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	01440		

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01440	Continued From page 15 by: Based on 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)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C began employment on July 27, 2024. ULP-C's employee record showed documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services, but it was completed by owner/licensed assisted living director (O/LALD)-A. On March 4, 2025, O/LALD-A stated she has been through many nurses and was between nurses at the time and did not know what to do so she completed it herself. O/LALD further stated she did many of them when she was without a nurse. The licensee's undated Supervision of Unlicensed Personnel policy indicated staff who perform delegated nursing or therapy tasks will be supervised by an appropriate licensed health professional or a registered nurse in accordance	01440		

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01440	Continued From page 16 with facility policy. 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 delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for one of one employee unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on July 27, 2024, to	01490		

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01490	Continued From page 17 provide direct care services. ULP-C's employee record lacked evidence of completing dementia care training in the following topics: - an explanation of Alzheimer's disease and other dementia's - assistance with activities of daily living - problem solving with challenging behaviors - communication skills and - person-centered planning and service delivery. On March 4, 2025, at 9:20 a.m., owner/licensed assisted living director (O/LALD)-A stated ULP-C completed dementia training but is unable to find documentation of the training. The licensee's Dementia Care Training policy dated March 19, 2024, indicated dementia care training will include: An explanation of Alzheimer's Disease and other dementias Assistance with activities of daily living Problem solving with challenging behaviors Communication skills Person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

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01530	Continued From page 18 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01530		

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01530	Continued From page 19 The findings include: ULP-C began employment on July 27, 2024, to provide direct care services. On March 3, 2025, at 12:20 p.m., the surveyor observed ULP-C prepare and administer medications for residents. ULP-C's orientation and training records lacked documentation of any of the required number of hours of dementia care training. On March 4, 2025, at 9:20 a.m., owner/licensed assisted living director (O/LALD)-A stated ULP-C completed dementia training but is unable to find documentation of the training. The licensee's Assisted Living Dementia Training policy dated June 21, 2024, indicated direct-care staff will complete a minimum of 8 hours of initial training on dementia care topics, initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 20 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed assessments and failed to use 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) 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: R1 was admitted and began receiving services on April 25, 2023.	01620		

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01620	Continued From page 21 R1's record showed an admission nursing assessment dated April 24, 2023, a 14-day assessment dated May 7, 2023, and subsequent assessments dated approximately 90 days apart with the most recent dated January 26, 2025. All but two of these assessments were signed by clinical nurse supervisor (CNS)-B. Additionally, the assessments did not include all the required elements of the uniform assessment tool. CNS-B's hire date was February 6, 2025. On March 4, 2025, at 11:15 a.m., owner/licensed assisted living director (O/LALD)-A stated she has been through many registered nurses since opening the facility and was not sure what to do with the assessments that were left unsigned by previous nurses, so she asked CNS-B to sign them. O/LALD further stated the same assessment forms were used for all the resident assessments and do not meet the requirements of the uniform assessemnt tool. On March 4, 2025, at 3:15 p.m., CNS-B stated O/LALD-A asked her to look at the past assessments and said it would be okay for her to sign them. CNS-B stated she knew it was not the right thing to do but did it anyway. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each licensee must develop a uniform assessment tool to include all the required elements. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in,	01620		

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01620	Continued From page 22 whichever is earlier. The assessment will be done by a registered nurse and will assess the physical and cognitive needs of the prospective resident and propose a temporary service plan. A comprehensive assessment is conducted by a registered nurse pre-admission, completed within14 days after start of services, with change in condition and at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 23 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content 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 the residents). The findings include: R1 was admitted and began receiving services on April 25, 2023. R1's service plan dated March 1, 2024, showed R1 received services to include assistance with dressing, grooming, walking, self-administration of medications, verbal or visual medical reminders, and managing anxiety, repetitive behavior, and agitation, but lacked the following: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences - the identification of staff or categories of staff	01650		

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01650	Continued From page 24 who will provide the service -the schedule and methods of monitoring assessments of the resident -the schedule and methods of monitoring staff providing services -a contingency plan that includes: -information and a method to contact the facility On March 4, 2025, owner/licensed assisted living director (O/LALD)-A stated they thought all the service plan requirements had been covered. The licensee's undated Service Plan policy indicated service plans will include the above missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for one of one resident (R1). This practice resulted in a level two violation (a	01710		

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01710	Continued From page 25 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: R1 admitted to the licensee and began receiving services on April 25, 2023. R1's medication administration record for March 2025 indicated R1 received medication administration daily. R1's medication assessment was dated April 25, 2023. On March 4, 2025, at 11:15 a.m., owner/licensed assisted living director (O/LALD)-A stated there have been a few nurses that have worked here, and things got missed, that is why the medication assessment had not been updated. The licensee's undated Individualized Medication Management Plan and Record policy indicated the registered nurse (RN) will monitor and reassess the resident's medication management services as needed at the nurse's periodic monitoring visits (at least every 90 days or more frequently based on the RN's judgement). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01730	Continued From page 26	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOOR OF GRACE LLC	152 102ND LANE NE BLAINE, MN 55434

(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
01730	Continued From page 27 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content 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 the residents). The findings include: R1 admitted to licensee and began receiving services on April 25, 2023. R1's medication administration record for March 2025 indicated R1 received medication administration daily. R1's medication assessment dated April 25, 2023, indicated R1 needed for assistance with medication administration. R1's 90-day assessment dated January 6, 2025, indicated R1 was independent with medication assistance and administration.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38054	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOOR OF GRACE LLC	152 102ND LANE NE BLAINE, MN 55434

(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
01730	Continued From page 28 R1's service plan dated March 1, 2024, indicated R1 needed assistance with self-administration of medications and verbal or visual medical reminders. R1's medication plan lacked the following: - a statement describing the medication management services that will be provided - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions - documentation of specific resident instructions relating to the administration of medications - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis - identification of medication management tasks that may be delegated to unlicensed personnel - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services - any resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. - The medication management record must be current and updated when there are any changes. On March 4, 2025, at 11:15 a.m., owner/licensed assisted living director (O/LALD)-A stated there have been a few nurses that have worked here, and things got missed, that is why the medication assessments have not been updated.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38054	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOOR OF GRACE LLC	152 102ND LANE NE BLAINE, MN 55434

(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
01730	Continued From page 29 The licensee's undated Individualized Medication Management Plan and Record policy indicated following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following above missing required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Follow-Up
Date: *03/14/25*
Time: 13:24:59
Report: 1029251070

Food and Beverage Establishment Inspection Report

Location:

Door Of Grace LLC
152 102nd Lane NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0041110
Risk:
Announced Inspection: Yes

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.

No NEW orders were issued during this inspection.

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

ESTABLISHMENT CLEARED ALL PREVIOUSLY ISSUED CORRECTION ORDERS.

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 1029251070 of 03/14/25.

Certified Food Protection Manager: DORETTE MEFEUNE

Certification Number: 38765 Expires: 04/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

DORETTE MEFEUNE
LALD

Signed: *Trevor McCliment*

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *03/04/25*
Time: 09:40:19
Report: 1029251064

Food and Beverage Establishment Inspection Report

Location:

Door Of Grace LLC
152 102nd Lane NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0041110
Risk:
Announced Inspection: Yes

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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

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.

NO EMPLOYEE ILLNESS LOG. NAVIGATED TO MDH SITE AND PRINTED EMPLOYEE ILLNESS LOG. REP INSTRUCTED TO MAINTAIN. ILLNESS LOGGING AND REPORTING REQUIREMENTS COVERED.

Comply By: 03/04/25

3-200A Food Characteristics: approved source

3-201.11B ***** Priority 1 *****

MN Rule 4626.0130B Remove all foods that were prepared or stored in a private home from the premises, except as allowed in Minnesota Statutes 28A.15 and 157.22 clauses 6 and 7.

MILK AND OTHER TCS ITEMS PURCHASED FROM GROCERY STORE YESTERDAY AND STORED AT REP'S PERSONAL RESIDENCE OVERNIGHT AND THEN TRANSPORTED TO ALF THIS MORNING. REP INSTRUCTED TO NOT STORE FOODS IN UNAPPROVED AREAS.

Comply By: 03/04/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS ITEMS IN COOLER IN DANGER ZONE DISCARDED BY REP. COOLER W/ SETTING 0-9, 9 BEING THE COLDEST, WAS SET AT 2. REP ADJUSTED TO 3. REP INSTRUCTED TO VERIFY

SAFE TEMPS PRIOR TO PLACING MORE TCS FOODS INTO COOLER.

Comply By: 03/04/25

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OPENED SHREDDED CHEESE W/ JANUARY DATE MARK AND GRAVY W/ NOVEMBER 2024 DATE MARK. DISCARDED BY REP. DATE MARKING AND LISTERIA COVERED W/ REP.

Comply By: 03/04/25

2-100 Supervision

2-102.11DEFG ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

REP UNAWARE OF CORRECT COOKING TEMP FOR RAW ANIMAL PROTEIN. TIME AND TEMP REQUIREMENTS DISCUSSED.

Comply By: 03/04/25

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLE W/ QUATERNARY AMMONIUM NOT LABELED. REP INSTRUCTED TO LABEL WITH "QUATERNARY AMMONIUM" OR "QUAT" ON BOTTLE.

Comply By: 03/04/25

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

INTERNAL THERMOMETER PLACED IN REAR OF CAVITY SHOWING ~41F. ITEMS IN COOLER GREATER THAN 41F. THERMOMETER MOVED TO FRONT OF REFRIGERATOR DURING INSPECTION.

Comply By: 03/04/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COOLER NOT MAINTAINING SAFE COLD HOLDING TEMPS. REP ADJUSTED. REP INSTRUCTED TO REPAIR OR REPLACE IF COOLER CANNOT MAINTAIN SAFE HOLDING TEMPS.

Comply By: 03/04/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING NOTIFICATION SIGNS ABSENT AT KITCHEN SINK. REP INSTRUCTED TO PROVIDE SIGNAGE WHERE EMPLOYEES CAN WASH THEIR HANDS.

Comply By: 03/04/25

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 300 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLDING/MILK
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: COLD HOLDING/MILK
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: COLD HOLDING/HOT DOGS
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: COLD HOLDING/SHRED CHEESE
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: COLD HOLDING/GRAVY
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR DOOR
Violation Issued: Yes

Type: Full
Date: *03/04/25*
Time: 09:40:19
Report: 1029251064
Door Of Grace LLC

Food and Beverage Establishment Inspection Report

Process/Item: COLD HOLDING/SHELL EGGS
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	2	3

FOOD AND BEVERAGE SERVICE INSPECTION PERFORMED AS PART OF HRD SURVEY OF FACILITY. KITCHEN RESIDENTIAL IN NATURE WITH SAME DAY SERVICE FOR PREPARED ITEMS. FACILITY SERVES CLIENTS, ONE OF WHICH IS PART OF A HIGHLY SUSCEPTIBLE POPULATION.

TOPICS REVIEWED:
- EMPLOYEE ILLNESS LOGGING AND EXCLUSION PRACTICES
- COMMON FOODBORNE ILLNESS PATHOGENS AND REPORTING REQUIREMENTS
- VOMIT-FECAL MATTER CLEANUP PROCEDURE
- EMPLOYEE HYGIENE AND HANDWASHING
- HEAT AND CHEMICAL SANITIZING
- TEMPERATURE CONTROL
- HIGHLY SUSCEPTIBLE POPULATION
- DATE MARKING AND LISTERIA

ALL IDENTIFIED ISSUES REVIEWED WITH ESTABLISHMENT REPRESENTATIVE AND NURSING EVALUATOR.

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 1029251064 of 03/04/25.

Certified Food Protection Manager: DORETTE MEFEUNE
Certification Number: 38765 Expires: 04/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
DORETTE MEFEUNE
LALD

Signed: *Trevor McCliment*
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029251064

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	5	Date	03/04/25
No. of Repeat RF/PHI Categories Out	0	Time In	09:40:19
Legal Authority MN Rules Chapter 4626		Time Out	

Door Of Grace LLC	Address: 152 102nd Lane NE	City/State: Blaine, MN	Zip Code: 55434	Telephone
License/Permit #: 0041110	**Permit Holder**	**Purpose of Inspection:** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/05/25

Inspector (Signature) *Trevor McCliment*