Electronically Delivered

May 23, 2023

Licensee
Shepherd Of Grace LLC
11175 27th Avenue Southeast
Becker, MN 55308

RE: Project Number(s) SL24881015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24881	A. BUILDING: _____ B. WING _____	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF GRACE LLC	11175 27TH AVENUE SE BECKER, MN 55308

(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: SL#24881015 On May 1, 2023, through May 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 60 active residents; 31 receiving services under the Assisted Living with Dementia Care 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 1, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 2 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's record lacked an IAPP. On May 1, 2023, at 1:35 p.m., licensed assisted living director (LALD)-A stated they had not developed IAPP's for any of their independent residents. The licensee's Vulnerable Adult Reporting policy revised August 1, 2021, indicated an abuse	0 630		

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0 630	Continued From page 3 prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services. The individual abuse prevention plan will include an individualized review or assessment of the resident's: - susceptibility to abuse by another individual, including other vulnerable adults - risk of abusing other vulnerable adults - specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 4 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 and failed to maintain testing and maintenance records for the emergency generator as part of the emergency preparedness plan. This had the potential to affect all residents receiving services under the assisted living with dementia license. 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: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority;	0 680		

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0 680	Continued From page 5 - subsistence needs for staff and residents including safe/sanitary storage of provisions; - system to track the location of on-duty staff and sheltered residents; - system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policies and procedures for volunteers, including the process/role for integration; - role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - develop and maintain EP training and testing program; - 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 table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On May 1, 2023, at 10:56 a.m., licensed assisted living director (LALD)-A stated, "I know our EPP is not as robust as it should be." A record review and interview were conducted on	0 680		

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0 680	Continued From page 6 May 2, 2023, by the engineer at approximately 12:00 p.m. with the Maintenance/ Engineering Vice president (ME)-F on the generator maintenance logs for the facility. A record review of the available documentation indicated that the licensee did not have records of required weekly inspection and maintenance of the emergency generator and required monthly load testing of the emergency generator as required by NFPA 110. During interview, ME-F indicated that the licensee did not have any records to provide for review for compliance. The licensees Emergency and Disaster Preparedness policy dated August 2021, indicated the facility will be prepared to manage emergency and disaster situations, including missing residents through our hazzard assessment and emergency planning. The specifics are located in the Emergency preparedness book (Red Book). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 8 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 02, 2023, at approximately 1:00 p.m. with the housing manager (HM)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Review of the evacuation plan diagrams showed that the location and number of resident sleeping rooms were not provided. HM-D verified this deficient condition. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, HM-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, HM-D stated the licensee was offering training to employees at orientation and one time annually through a third-party online training platform but did not	0 810		

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0 810	Continued From page 9 have any documentation on training that included completion dates nor a policy on training employees. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were completed on 04/10/2023, 03/17/2023, 02/7/2023, 10/4/2022, and 08/11/2021. During interview, HM-D verified that there were no further documented drills for the facility, verified the policy lacked language regarding evacuation drills, and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950		

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0 950	Continued From page 10 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of two residents (R3, R4). 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 the residents). The findings include: R3 R3's record included an Assisted Living Contract signed October 6, 2022. R4 R4's record included an Assisted Living Contract signed January 18, 2023.	0 950		

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0 950	Continued From page 11 R3 and R4's assisted living contracts lacked to include statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' in a separate page in the contract. On May 2, 2023, at 11:23 a.m., licensed assisted living director (LALD)-A stated the designated representative portion for residents to fill out was included in the contract and this is the same contract they use for all residents. On May 2, 2023, at 1:02 p.m., LALD-A indicated via email, "It was an addendum to our bill of rights (BOR) prior to the updated BOR last August, however that page must have been inadvertently deleted with the BOR update. Also, I noticed that the acknowledgement form did not reference that verbiage either". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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:	0 970		

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0 970	Continued From page 12 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility'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 the residents). The findings include: The licensee's current assisted living contract included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 10, number 28 Miscellaneous Provisions indicated Resident shall at all times be responsible for the safety of his/her belongings. The Resident will hold the owner, harmless and keep it exonerated from all loss, damage, liability, or expense that happened or claimed by reasons of acts or neglects of the resident or their employees or visitors or independent contractors engaged or paid by the resident whether in the leased premises or elsewhere in the building or its approaches, unless proximately caused by the negligent acts of the owner. Resident is encouraged to carry renter's insurance to protect himself/herself against any and all such losses. Insurance carried by Owner does not cover any property of Resident. On May 2, 2023, at 11:55 a.m., licensed assisted	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24881	A. BUILDING: _____ B. WING _____	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF GRACE LLC	11175 27TH AVENUE SE BECKER, MN 55308

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0 970	Continued From page 13 living director (LALD)-A stated they will need to reread the statute, they went through the contract with a provider group but did not circle back to make sure it was corrected. On May 2, 2023, via an email received at 1:02 p.m., LALD-A stated in our contract #28 is in reference to the resident's guests and the statute talks about liability being prohibited in terms of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the memory care unit. 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	01880		

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01880	Continued From page 14 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 May 2, 2023, at 7:55 a.m., the surveyor observed on a desk in the common area, the memory care medication refrigerator which lacked a functional locking mechanism. The fridge contained one bottle of Latanoprost 0.005 percent eye drop solution for one resident. There were four residents and one staff sitting in the common area. On May 2, 2023, at 1:50 p.m., registered nurse (RN)- stated "All medications here in memory care need to be locked up so residents do not have access to them, and we keep our medication fridge locked all the time." The surveyor, with the RN observed that the locking mechanism on the refrigerator was broken, and the medications were not secure. The licensee's Storage of Medications policy dated August 2021,indicated when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24881	A. BUILDING: _____ B. WING _____	05/02/2023

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01890	Continued From page 15 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 On May 2, 2023, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)- E administer R4's morning medications which included a Trellegy Ellipta inhaler.The inhaler did not include an opened or expired date. On May 2, 2023, at 8:20 a.m., ULP-E stated that the inhaler should contain a sticker that indicates the date it was opened. The manufacturer's instructions dated December	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 16 2022, for Trellegy Ellipta inhaler directed to safely throw away inhaler in the trash 6 weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler. R5 On May 2, 2023, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)- E administer R5's morning medications which included a Stiolto Respimat inhaler. The inhaler did not include an opened or expired date. On May 2, 2023, at 8:45 a.m., ULP-E stated the inhaler should contain a sticker that indicates the date it was opened. The manufacturer's instructions dated November 2021, for Stiolto Respimat inhaler directed three months after insertion of cartridge, throw away the Stiolto Respimat even if it has not been used, or when the inhaler is locked, or when it expires, whichever comes first. On May 2, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-C stated the facility is no longer labeling medications with an open date because the pharmacy sent them an updated list of expiration dates and told them they no longer need to be labeled. CNS-C stated without an open date the unlicensed staff would not know when the medication should no longer be used. The licensees Storage of Medications policy dated August 2021, indicated proper storage of medications: -the RN will recommend where medications should be stored understanding that our agency may not be able to control where and how a resident stores his/her medications in their room.	01890		

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01890	Continued From page 17 The RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. this may include a combination of the residence room and the nursing office. -until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, residents name, prescribers name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions.	02170		

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02170	Continued From page 18 (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R3, R4) who resided in the assisted living with dementia care 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02170		

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02170	Continued From page 19 or has the potential to affect a large portion or all the residents). The findings include: R3 R3's diagnoses included type 2 diabetes mellitus, dementa with no behavior difficulties, and hyperlipidemia (high cholesterol). R3's Assessment As of Date, dated April 13, 2023, indicated R3 was assessed for the following activities: - interests and talents. R4 R4's diagnoses included fracture of right pubis, post-traumatic stress disorder, dementia with behavioral disturbances. R4's Master Care Plan, dated January 11, 2023, indicated R4 was evaluated for the following activities: - past and current interests. R3 and R4's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R3 and R4's records lacked the development of an individualized activity plan	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02170	Continued From page 20 On May 2, 2023, at 11:23 a.m., licensed assisted living director (LALD)-A stated they are unable to find the activity evaluation that includes all the required information and they do not have an activity plan. LALD-A stated this would be the case for all the residents. The licensee's Initial and On-Going Nursing Assessments of Clients, revised August 2021, indicated the comprehensive assessment will include: -the resident's personal lifestyle preferences including sleep schedule, dietary and social needs, leisure activities, and other customary routines that are important to the resident's quality of life -spiritual and cultural preferences No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/01/23*
Time: 11:55:57
Report: 1037231114

Food and Beverage Establishment Inspection Report

Location:
Shepherd Of Grace Llc
11175 27th Avenue Se
Becker, MN55308
Sherburne County, 71

Establishment Info:
ID #: 0038707
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634506675
ID #:

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

The following orders were issued during this inspection.

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

3-302.13 ** Priority 1 **

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

DISCONTINUE USING UNPASTEURIZED EGGS THAT ARE SOFT COOKED. PASTEURIZED EGGS MUST BE SUBSTITUTED FOR RAW EGGS IN THE PREPARATION OF A PARTIALLY COOKED ANIMAL FOOD SUCH AS SUNNY SIDE UP OR OVER EASY EGGS.

Comply By: 05/01/23

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.

PACKAGED ORANGE JUICE IN THE GALANZ UPRIGHT COOLER IN THE COTTAGES KITCHEN A WAS READING 49 DEG F. REPAIR OR ADJUST COOLER TO MAINTAIN FOODS AT OR BELOW 41 DEG F.

Comply By: 05/01/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE AN IRREVERSIBLE REGISTERING TEMPERATURE MEASURING INDICATOR FOR MEASURING THE TEMPERATURE OF THE UTENSIL SURFACE LEVEL FOR BOTH

MECHANICAL HOT WATER DISHWASHERS.
Comply By: 06/01/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

BOXES AND BINS OF FOOD WERE BEING STORED ON THE FLOOR IN THE WALK-IN FREEZER. STORE ALL FOOD ITEMS AT LEAST 6 INCHES ABOVE THE FLOOR.
Comply By: 05/08/23

Surface and Equipment Sanitizers

Hot Water: = at 172 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Hot Water: = at 174 Degrees Fahrenheit
Location: DISHWASHER - COTTAGES KITCHEN A
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: BEEF STEAK
Violation Issued: No

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: TURKEY IN GRAVY
Violation Issued: No

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: MASHED POTATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: MIXED VEGETABLES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: CUT MELON
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: WHIPPED CREAM - COTTAGES KITCHEN B
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 49 Degrees Fahrenheit - Location: PACKAGED ORANGE JUICE - COTTAGES KITCHEN A
Violation Issued: Yes

Type: Full
Date: *05/01/23*
Time: 11:55:57
Report: 1037231114
Shepherd Of Grace Llc

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the inspection report number 1037231114 of 05/01/23.

Certified Food Protection Manager: AMANDA M SPIERING

Certification Number: 107637 Expires: 08/10/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231114

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1	Date	05/01/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:55:57
Legal Authority MN Rules Chapter 4626		Time Out	

Shepherd Of Grace Llc	Address: 11175 27th Avenue Se	City/State: Becker, MN	Zip Code: 55308	Telephone: 7634506675
License/Permit #: 0038707	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
Surpervision			
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

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

			COS	R
Proper Use of Utensils				
43				
In-use utensils: properly stored				
44				
Utensils, equipment & linens: properly stored, dried, & handled				
45				
Single-use/single service articles: properly stored & used				
46				
Gloves used properly				
Utensil Equipment and Vending				
47				
Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48	X			
Warewashing facilities: installed, maintained, & used; test strips				
49				
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:** 05/01/23

Inspector (Signature) Michelle L Thomas