DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 26, 2025

Licensee
Grace Haven Assisted Living
301 3rd Street East
Madison, MN 56256

RE: Project Number(s) SL30808016

Dear Licensee:

On May 5, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 21, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin Zwart

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

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Electronically Delivered

March 26, 2025

Licensee
Grace Haven Assisted Living
301 3rd Street East
Madison, MN 56256

RE: Project Number(s) SL30808016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 21, 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.

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30808	A. BUILDING: _____ B. WING _____	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HAVEN ASSISTED LIVING	301 3RD STREET EAST MADISON, MN 56256

(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: SL30808016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 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 held an assisted living license with a bed capacity of 10 residents and had a current census of five residents. On February 18, 2025, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they only have a staffing policy and the current schedule, they do not have a staffing plan that has been evaluated twice a year. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated February 20, 2025, indicated a clinical nurse supervisor, or designee, will develop, write, and implement a staffing plan. The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 3 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 4 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 undated emergency preparedness plan (EPP), lacked the required content: - development and maintenance of the EPP; - maintained annual updates; - a quarterly review of missing resident policy; - the development of policies/procedures to address: - use of volunteers; and - roles under a waiver declared by the secretary; - emergency officials contact information to include: -state licensing and certification agency; and -MN Office of Ombudsman for LTC. On February 19, 2025, at 10:00 a.m., licensed assisted living facility/clinical nurse supervisor (LALD/CNS)-A stated they did not review or update the EPP annually, the missing person policy quarterly, and she would agree the EPP is missing some of the required information. LALD/CNS-A stated they were planning on updating the whole EPP but have not gotten to it yet, which is why it is missing some of the required information. The licensee's Emergency and Disaster Preparedness policy dated February 20, 2025, indicated the licensee will be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning. The emergency operations plan, communications plan, and the policies and procedures listed will	0 680		

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0 680	Continued From page 5 be reviewed and updated at least annually. The licensee's Missing Resident policy dated February 20, 2025, indicated the assisted living director and clinical nurse supervisor will review the missing resident plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was 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: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. 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 pattern scope (when more than a limited number	0 775		

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0 775	Continued From page 6 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: During facility tour on February 20, 2025, from 10:24 a.m. through 10:52 a.m. with housing manager/unlicensed staff (HM/ULP)-B and director of maintenance (DOM)-E, the surveyor observed emergency escape and rescue windows that did not open in the following resident sleeping rooms: Unoccupied rooms four and nine. Occupied rooms one, two, three and ten. During the tour HM/ULP-B and DOM-E verified the above findings and stated that the windows were froze shut so they were not able to open them. State Fire Code in Minnesota Rules, chapter 7511 requires means of egress be maintained in operable condition, so they are available to use during a fire or similar emergency. During an interview on February 20, 2025, at 11:30 a.m. HM/ULP-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that facility staff would wipe moisture off the windows twice per day to keep them from freezing shut. HM/ULP-B and LALD/CNS-A stated they understood the requirement and would have staff wipe the windows more often and operate the windows to ensure they opened. TIME PERIOD FOR CORRECTION: Two (2)	0 775		

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0 775	Continued From page 7 days.	0 775		
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. This MN Requirement is not met as evidenced	0 810		

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0 810	Continued From page 8 by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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 February 20, 2025, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and housing manager/unlicensed staff (HM/ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensees FSEP, untitled and undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but had not been updated to provide complete actions for employees to take in the event of a fire or similar	0 810		

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0 810	Continued From page 9 emergency at the licensed facility. The plan failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on February 20, 2025, at 11:30 a.m., LALD/CNS-A and HM/ULP-B stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 10 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 11 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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 ULP-C started employment on September 12, 2020, and began providing services under the assisted license on August 1, 2021. On February 19, 2025, at 9:15 a.m., the surveyor observed ULP-C administer medications to R1.	01470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 12 ULP-C's employee record lacked the following required orientation content: - an overview of the assisted living statutes; - the AL BOR and staff responsibilities related to ensuring the exercise and protection of those rights; and - principles of person-centered planning and service delivery. ULP-D ULP-D started employment on January 22, 2025, to provide direct care services to the licensee's residents. ULP-D's employee record lacked the following required orientation content: - an overview of the assisted living statutes; and - principles of person-centered planning and service delivery. On February 20, 2025, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees the unlicensed staff are missing some of the required orientation topics and this is due to using old home care orientation paperwork when assigning classes and this would be the case for all of the employees. The licensee's Assisted Living-All Staff policy dated February 20, 2025, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following topics: - An overview of Minnesota's assisted living laws; - The assisted living Bill of Rights and staff responsibilities to ensuring the exercise and	01470		

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	30808	A. BUILDING: _____ B. WING _____	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HAVEN ASSISTED LIVING	301 3RD STREET EAST MADISON, MN 56256

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01470	Continued From page 13 protection of those rights; and - Principles of person centered planning and service delivery and how they apply to direct support services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 14 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (housing manager/unlicensed staff (HM/ULP-B) and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500		

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01500	Continued From page 15 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: HM/ULP-B HM/ULP-B started employment on November 14, 2011, and began providing services under the assisted living license on August 1, 2021. HM/ULP-B's employee record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; - Infection control techniques; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery. ULP -C ULP-C started employment on September 12, 2020, and began providing services under the assisted license on August 1, 2021. On February 19, 2025, at 9:15 a.m., the surveyor observed ULP-C administer medications to R1. ULP-C's employee record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; - Infection control techniques; - Review of provider's policies and procedures;	01500		

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01500	Continued From page 16 and - Principles of person-centered planning/service delivery. On February 20, 2025, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees the employee annual training is missing some of the required topics. LALD/CNS-A stated this is due to assigning incorrect classes, missed assignment of some of the required classes, and this would be the case for all of the employees related to annual training. The licensee's Assisted Living Annual Training policy February 20, 2025, indicated all assisted living employees will complete annual education on the following topics: - Reporting of maltreatment of vulnerable adults; - Infection control techniques used in the home and implementation of infection control standards; - Review of policies and procedures related to the provision of assisted living services and how to implement them; and - Principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940		

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01940	Continued From page 17 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (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	01940		

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01940	Continued From page 18 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 18, 2025, at 1:30 p.m., during a tour of the facility, the surveyor observed a CPAP machine on R1's nightstand. On February 19, 2025, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1 was admitted to the licensee on January 14, 2012, and began receiving assisted living services on August 1, 2021. R1's Service Plan dated February 18, 2025, indicated R1 received services for medication administration, continuous positive airway pressure (CPAP), dressing, grooming, bathing, toileting, hearing aid assistance, meal assistance, behavior monitoring, housekeeping, and laundry. R1's signed provider orders dated July 3, 2024, included CPAP service twice daily and CPAP maintenance once a week. R1's Service Recap Summary dated January 1, 2025, through February 18, 2025, included services CPAP twice daily and CPAP maintenance once a week. R1's Individualized Treatment and Therapy Plan dated February 18, 2025, lacked information related to the CPAP.	01940		

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01940	Continued From page 19 R1's individualized treatment management plan lacked the following required content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On February 19, 2025, at 2:30 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated they were not aware that a CPAP was considered a treatment which is why it is not included on the treatment plan. LALD/CNS-A also stated that she did not realize specific instructions for each treatment or therapy would need to be in the treatment plan for the unlicensed staff to reference. The licensee's Individualized Medication, Treatment & Therapy Management Plan policy dated February 20, 2025, indicated the RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include: - statement of the type of services provided; - documentation of specific resident instructions relating to the treatments and/or therapy	01940		

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01940	Continued From page 20 administration; - identification of treatment or therapy task that may be delegated to an unlicensed staff member; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services; - resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment and/or therapy to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950		

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01950	Continued From page 21 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) when providing assistance with continuous positive airway pressure (CPAP) therapy. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP -C ULP-C started employment on September 12, 2020, and began providing services under the assisted license on August 1, 2021. R1's Service Recap Summary dated January 2025, indicated ULP-C assisted R1 with CPAP on January 13, 19, and 27, 2025. R1's Service Recap Summary dated February 2025, indicated ULP-C assisted R1 with CPAP on February 2, 7, and 10, 2025. ULP-D ULP-D started employment on January 22, 2025, to provide direct care services to the licensee's residents.	01950		

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01950	Continued From page 22 R1's Service Recap Summary dated January 2025, indicated ULP-D assisted R1 with CPAP on January 31, 2025. R1's Service Recap Summary dated February 2025, indicated ULP-D assisted R1 with CPAP on February 1, 3, 6, 9, 11, 12, 13, and 17, 2025. ULP-C and ULP-D's employee records both lacked documentation of training and competency evaluation to include: -CPAP assistance. On February 19, 2025, at 2:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the unlicensed staff were missing the training and competency on CPAP assistance because she did not realize that CPAP was a treatment, and all staff would require the training and competency on CPAP. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated February 20, 2025, indicated the RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements: - The RN has communicated information about the medication treatment, or therapy to the resident and provided education if needed; - Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures; - The RN has developed written, specific instruction for each resident;	01950		

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01950	Continued From page 23 - The RN has communicated with the unlicensed personnel about the individual needs of the resident; and - The RN has documented the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01950		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *02/18/25*
Time: 14:11:42
Report: 7935251017

Food and Beverage Establishment Inspection Report

Location:
Grace Haven Assisted Living
301 3rd Street East
Madison, MN56256
Lac Qui Parle County, 37

Establishment Info:
ID #: 0037739
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205987557
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.

Surface and Equipment Sanitizers

Hot Water: = at 160+ Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

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

Type: Full
Date: *02/18/25*
Time: 14:11:42
Report: 7935251017
Grace Haven Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 7935251017 of 02/18/25.

Certified Food Protection Manager: Debbie Werner

Certification Number: 98249 Expires: 04/12/25

Signed: _____
Establishment Representative

Signed: _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us