Electronically Delivered

March 29, 2024

Licensee
Living Grace Home Care
10253 Mississippi Boulevard
Coon Rapids, MN 55433

RE: Project Number(s) SL35605015

Dear Licensee:

On February 7, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 26, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 26, 2023 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 26, 2023, found not corrected at the time of the February 7, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1)
0790 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (2)-(3)

The details of the violations noted at the time of this follow-up survey completed on February 7, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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**.

Also, at the time of this follow-up survey completed on February 7, 2024, we identified the following violation(s):

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the

attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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

Sincerely,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35605	A. BUILDING: _____ B. WING _____	R 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING GRACE HOME CARE	10253 MISSISSIPPI BOULEVARD COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35605015-1 On February 7, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed October 23 through October 26, 2023. At the time of the survey, there were 4 residents; all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: No further action needed.	{0 110}		

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{0 460}	Continued From page 1	{0 460}		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action needed.	{0 460}		
{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	{0 470}		

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{0 470}	Continued From page 2 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action needed.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}		

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{0 650}	Continued From page 3 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	{0 700}		

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{0 700}	Continued From page 4 This MN Requirement is not met as evidenced by: No further action needed.	{0 700}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements.	{0 780}		

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{0 780}	Continued From page 5 This had the potential to directly affect all residents and staff. 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). Findings include: On February 7, 2024, at 2:15 p.m., survey staff toured the facility with administrator (A)-A. During the tour, survey staff observed when the main floor hallway smoke alarm was tested, none of the other smoke alarms in the dwelling unit were activated. During the facility tour interview, A-A verified this smoke alarm was not interconnected.	{0 780}		
{0 790} SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}		

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{0 790}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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) 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 February 7, 2024, at 2:15 p.m., survey staff toured the facility with administrator (A)-A. During the tour, survey staff observed the monthly inspection records were blank on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, A-A verified monthly inspections had not been performed on the fire extinguishers.	{0 790}		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 7 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 February 7, 2024, at 2:15 p.m., survey staff toured the facility with administrator (A)-A. During the tour, survey staff observed the following: 1. The sill height of the egress windows measured 52 inches from the floor in occupied basement bedrooms 3 and 4. A step, platform, or bed was not located under these windows. The maximum height from the floor to the window sill shall not exceed 48 inches. Egress windows with openings up to 52 inches off the floor can be approved if those windows meet the height	0 800		

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0 800	Continued From page 8 requirement for existing buildings by providing a secure step, platform, or bed directly underneath the window. This step, platform, or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person occupying the bedroom. During the facility tour interview, A-A verified the egress window sill heights in these bedrooms required a step, platform, or bed under the windows and stated this would be corrected. 2. Burnt cigarettes were on the ground outside the back door. During the facility tour interview, A-A verified the burnt cigarettes had been improperly disposed of and explained the licensee provided a container for cigarette disposal on the deck. TIME PERIOD FOR CORRECTION: Seven (7 days)	0 800		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action needed.	{0 910}		

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{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: No further action needed.	{0 920}		
{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.	{01880}		

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{01880}	Continued From page 10 This MN Requirement is not met as evidenced by: No further action needed.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs 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: No further action needed.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	{01910}		

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{01910}	Continued From page 11 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action needed.	{01910}		

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November 7, 2023

Licensee
Living Grace Home Care
10253 Mississippi Boulevard
Coon Rapids, MN 55433

RE: Project Number(s) SL35605015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 26, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35605	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING GRACE HOME CARE	10253 MISSISSIPPI BOULEVARD COON RAPIDS, MN 55433

(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: SL35605015 On October 23, 2023, through October 26, 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 four (4) active residents; all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on October 23, 2023, issued for SL35605015-0, tag identification 0820. On October 24, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of F.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 23, 2023, at 10:12 a.m., LALD/clinical nurse supervisor (CNS)-B identified LALD/CNS-B as the current LALD for the licensee. On October 23, 2023, at 1:26 p.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD/CNS-B. The BELTSS website indicated LALD/CNS-B had an assisted living director license (effective July 27, 2021; expires October 31, 2024). The website did not indicate LALD/CNS-B as the Director of Record for the licensee. LALD/CNS-B stated LALD/CNS-B was unaware the Director of Record needed to be listed on the BELTSS website.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for one of one resident (R2) to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all	0 460		

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0 460	Continued From page 3 four (4) residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of four (4) residents, with a census of four (4). During the entrance conference on October 23, 2023, at 10:16 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the licensee did not have a call system in place since the current residents could ambulate, and staff did safety checks on all residents frequently. R2's diagnoses included schizoaffective disorder, type 2 diabetes, and major depressive disorder. On October 24, 2023, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration for R2. During the observation, R2 stated if R2 needed assistance from staff, R2 would just walk out to staff and ask for assistance. R2's assessment dated October 12, 2023, indicated R2 was sometimes forgetful and displays confusion.	0 460		

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0 460	Continued From page 4 The licensee's undated Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated non-emergency call system was in place with a bell if resident was not independent. The licensee's 2.01 24-Hour Emergency Response policy dated August 1, 2021, indicated all residents at the facility would have access to 24-hour emergency response by staff. "Pressing the button on the emergency response button or pulling an emergency response cord will activate the response system which will notify a designated staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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,	0 470		

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0 470	Continued From page 5 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 ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. 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) 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: The licensee held an assisted living facility license and was licensed for a capacity of four (4) residents and a current census of four. During the entrance conference on October 23, 2023, at 10:13 a.m., licensed assisted living director (LALD)/CNS-B stated the licensee had a	0 470		

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0 470	Continued From page 6 staffing plan developed by administrator (A)-A and was reviewed frequently. The surveyor requested the staffing plan, which was later provided. On October 24, 2023, at 10:02 a.m., the surveyor reviewed the undated staffing plan with LALD/CNS-B. LALD/CNS-B stated the licensee purchased the staffing plan and LALD/CNS-B was not aware the staffing plan needed to be reviewed every six months by the CNS. The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the CNS will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 23, 2023, 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		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650		

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0 650	Continued From page 8 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all the required content 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 was hired on February 1, 2023, to provide direct care to residents at the assisted living facility. On October 24, 2023, at 7:13 a.m., the surveyor observed ULP-C complete scheduled morning medication administration for R2. ULP-C's employee record lacked training and competency evaluation documentation for resident unplanned time away. On October 24, 2023, at 6:57 a.m., ULP-C stated licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B completed ULP-C's medication training and competency testing.	0 650		

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0 650	Continued From page 9 On October 24, 2023, at 12:41 p.m., LALD/CNS-B stated all ULPs have completed training and competency testing on unplanned times away during the initial medication training and competency testing, and it was reviewed at staff meetings. LALD/CNS-B further stated all ULP employee records would lack proof as LALD/CNS-B did not document the trainings or competency testing for unplanned time away in the employee record. The licensee's 7.10 Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, indicated the registered nurse (RN) may delegate this task (unplanned time away) to ULP if the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medications to residents. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records will include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall	0 700		

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0 700	Continued From page 10 establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure four of four resident's (R2, R3, R4, R5) personal health and medical information was kept private. This had the potential to affect all four 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), 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: RESIDENT RECORDS From October 23, 2023, at 10:00 a.m., through October 24, 2023, at 2:45 p.m., the surveyor observed R2, R3, R4, and R5's resident record binders sitting on an open shelf upstairs. Each binder identified the resident's first and last name on the outside. The facility layout consisted of three floors (basement, main level, upstairs). The upstairs was referred to as the 'staff area only', however, was accessible to the main floor by three (3) stairs and did not have a door. On October 24, 2023, at 10:40 a.m., licensed assisted living director (LALD)/clinical nurse	0 700		

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0 700	Continued From page 11 supervisor (CNS)-B stated the upstairs area was for staff only and residents do not come to the upstairs. LALD/CNS-B further stated that the resident charts were not locked in a secure area, so potential anyone could access the resident records if they came upstairs. WHITEBOARD CALENDAR From October 23, 2023, at 10:00 a.m., through October 24, 2023, at 10:40 a.m., the surveyor observed a large whiteboard calendar hanging in the resident dining and living room on the main floor. The whiteboard listed the following information: -four appointments with R4's initials, dates, times, and what type of appointment; -one appointment with R5's initials, date, and who the appointment was with; -one appointment with R2's initials, date, and time of appointment; and -one appointment with R3's initials, date, time and who the appointment was with. On October 24, 2023, at 10:40 a.m., LALD/CNS-B stated the whiteboard calendar contained personal resident information about appointments and could be seen by anyone who was in the dining room or living room area. LALD/CNS-B stated the information listed was a privacy issue and would need be removed. The licensee's 2.12 Confidentiality policy dated August 1, 2021, indicated personal, financial, medical, or other private information regarding residents or staff should not be disclosed to any other person except: - as may be required by law - to other staff as appropriate or necessary to provide services - to persons authorized in writing by the resident	0 700		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 700	Continued From page 12 or resident's responsible person to receive information, including third party payers, or - to representatives of the commissioner authorized to survey or investigate any part of the community No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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	35605	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING GRACE HOME CARE	10253 MISSISSIPPI BOULEVARD COON RAPIDS, MN 55433

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0 780	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. 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). Findings include: On October 23, 2023, at approximately 11:00 a.m., survey staff toured the facility with administrator (A)-A. During the tour, survey staff observed that when smoke alarms were tested, the other smoke alarms in the dwelling unit were not activated. The smoke alarms were not interconnected. This deficient condition was verified A-A during an interview with survey staff on October 26, 2023, at approximately 9:00 a.m. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790		

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0 790	Continued From page 14 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide and maintain portable fire extinguishers as required by statute. This deficient condition 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) 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). Findings include: On October 23, 2023, at approximately 11:00 a.m., survey staff toured the facility with the administrator (A)-A. During the facility tour, survey staff observed the following: 1. Both installed portable fire extinguishers were 1-A:10BC rated. 2. Tags or labels were not attached to the portable fire extinguishers showing that annual	0 790		

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0 790	Continued From page 15 maintenance had been performed by certified service personnel. Fire extinguishers need to be maintained so that they can be used reliably and effectively in an emergency. 3.Monthly fire extinguisher inspections were not being completed. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. These deficient conditions were verified A-A during an interview with survey staff on October 26, 2023, at approximately 9:00 a.m. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 16 Based on observation and interview, the licensee failed to ensure the minimum height opening and the total clear openeable area for egress windows in two occupied resident bedrooms; and failed to ensure that routes for emergency escape were unobstructed. This had the potential to directly affect all residents, visitors, and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 October 23, 2023, at approximately 11:00 a.m., survey staff toured the home with the administrator (A)-A. 1. The egress windows were opened and measured in occupied bedrooms 3 and 4. The egress windows in these bedrooms measured less than 20 inches in height. Additionally, the clear openable area of both windows was less than 648 square inches. Bedroom 3 - 14"Hx30"W with a total clear openable area of 420 square inches Bedroom 4 - 16"Hx34"W with a total clear openable area of 544 square inches The windows in bedrooms 3 and 4 did not meet the minimum egress window opening height and total clear openable area required for safe egress. One window in each resident sleeping	0 820	his immediate correction order identified on October 23, 2023, has had the immediacy lifted as of October 24, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 17 room must meet the minimum window opening size of at least 20 inches in height and, a minimum width of 20 inches, with a total of at least 648 square inches (4.5 square feet). 2. Key only locks were installed on the front and back doors that were both designed as emergency exits. Locks controlled only by key from the inside could delay the occupant's ability to exit the building in a timely and efficient manner in the event of an emergency. These deficient conditions were verified by the A-A during an interview with survey staff on October 23, 2023, at approximately 12:50 p.m. TIME PERIOD FOR CORRECTION: Immediate On October 24, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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0 910	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Assisted Living Contract was signed by the resident on September 28, 2023. On October 24, 2023, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration for R2. R2's assisted living contract did not include the provider's identification number (HFID), legal name, phone number, address, or authorized agent. On October 24, 2023, at 9:44 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the same contract was used for all residents and was missing the provider's HFID, legal name, address, phone number, and authorized agent.	0 910		

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0 910	Continued From page 19 No further information as provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for	0 920		

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0 920	Continued From page 20 one of one resident (R2). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Assisted Living Contract was signed by the resident on September 28, 2023. On October 24, 2023, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration for R2. R2's Assisted Living Contract did not include the following information: - a disclosure of the category of assisted living facility license held by the facility; and - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract. On October 24, 2023, at 9:44 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the same contract was used for all residents and the above noted information was missing on the assisted living contract. No further information was provided.	0 920		

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0 920	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
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 medications were stored according to manufacturer's instructions for one of one medication refrigerator by failing to monitor and document medication refrigerator temperatures. 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: During the entrance conference on October 23, 2023, at 10:17 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility.	01880		

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01880	Continued From page 22 On October 23, 2023, at 12:29 p.m., the surveyor reviewed the medication refrigerator located in a locked room in the staff area (upstairs) with unlicensed personnel (ULP)-D. ULP-D stated the current refrigerator temperature was not known as the licensee did not check the medication refrigerator temperature and there was no thermometer in the medication refrigerator. ULP-D stated the medication refrigerator contained the following medications: -two (2) unopened Victoza 1.8 milligrams (mg) pens for R2. On October 23, 2023, at 12:30 p.m., LALD/CNS-B stated R2 had recently just moved to the facility and LALD/CNS-B had not developed a task for staff to complete checking the medication refrigerator temperature yet. LALD/CNS-B stated the medication refrigerator was not currently being monitored. The manufacturer's instructions for Victoza dated June 2022, indicated before opening store the pen in the refrigerator (36-46 degrees Fahrenheit). Do not allow Victoza to freeze. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 23 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 monitor for expired medications for one of four residents (R3). 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: During the entrance conference on October 23, 2023, at 10:17 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. On October 23, 2023, at 12:25 p.m., the surveyor reviewed the locked medication cabinets with unlicensed personal (ULP)-D. ULP-D stated the following: -two (2) unopened EpiPens 0.3 milligrams (mg)/0.3 milliliters (mL) for R3 expired September 2023.	01890		

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01890	Continued From page 24 On October 23, 2023, at 12:31 p.m., LALD/CNS-B stated LALD/CNS-B reviews the resident medications every two (2) weeks to check expiration dates and must have "missed" R3's EpiPens. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated any expired medication managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 25 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications to include the quantity as required for one of one resident (R1) upon discharge. 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: During the entrance conference on October 23, 2023, at 10:17 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. The licensee's Discharged or Deceased Resident Roster dated October 24, 2023 [sic], indicated R1 was admitted to the facility on July 25, 2023, and discharged on August 2, 2023. R1's diagnoses included diabetes, obesity, anxiety, and depression. R1's service plan dated July 25, 2023, indicated R1 received medication administration services.	01910		

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LIVING GRACE HOME CARE	10253 MISSISSIPPI BOULEVARD COON RAPIDS, MN 55433

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01910	Continued From page 26 R1's Medication Administration Record (MAR) for August 2023, indicated the resident received the following medications: -acarbose 25 milligram (mg) tablet (for low blood sugar)- take one tablet three times daily -gabapentin 100 mg tablet (for pain)- take 2 tablets three times daily -levetiracetam 500 mg tablet (for seizures)- take one tablet daily -acetaminophen 325 mg tablet (for pain)- take one tablet three times daily -amlodipine 5 mg tablet (for high blood pressure)- take one tablet daily -disulfiram 250 mg tablet (for alcohol dependency)- take one tablet daily -docusate sodium 100 mg tablet (for constipation)- take three tablets daily -lisinopril 40 mg tablet (for high blood pressure)- take one tablet daily -melatonin 3 mg tablet (for sleep)- take one tablet at bedtime -miralax 17 gram packet (for constipation)- take one packet daily -tab-a-vite tablet (supplement)- take one tablet daily -verenicline 1 mg tablet (supplement)-take one tablet twice daily -venlafaxine 150 mg tablet (for depression)- take one tablet daily -vitamin B-12 1000 micrograms (mcg) tablet (supplement)- take one tablet daily -zolpidem 5 mg tablet (for sleep)- take one tablet at bedtime -white petrolatum apply topically daily -hydroxyzine HCL 25 mg tablet (for anxiety)- take 2 tablets at bedtime -buspirone 15 mg tablet (for anxiety)- take one tablet twice daily -calcium carbonate chewable antacid 500 mg tablet (for heartburn)- take one tablet three times	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35605	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING GRACE HOME CARE	10253 MISSISSIPPI BOULEVARD COON RAPIDS, MN 55433

(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
01910	Continued From page 27 daily -methocarbamol 500 mg tablet (for muscle spasms)- take two tablets every six hours as needed -nicotine 4 mg tablet (for nicotine cravings)- take one tablet every two hours as needed -ondansetron 4 mg tablet (for nausea)- take one tablet every eight hours as needed R1's prescriber orders dated August 1, 2023, included the above noted medications. R1's Incident Report dated August 2, 2023, indicated R1 was discharged to home against medical advice. R1's record lacked documentation for the disposition of the following medications to include the medication quantity: -acarbose 25 mg -gabapentin 100 mg -levetiracetam 500 -acetaminophen 325 mg -amlodipine 5 mg -disulfiram 250 mg -lisinopril 40 mg -melatonin 3 mg -tab-a-vite -verenicline 1 mg -venlafaxine 150 mg -vitamin B-12 1000 mcg -white petrolatum -hydroxyzine HCL 25 mg -buspirone 15 mg -calcium carbonate chewable antacid 500 mg -ondansetron 4 mg tablet On October 24, 2023, at 1:26 p.m., LALD/CNS-B stated R1's medication disposition was lacking quantity of medications due to R1 having a ride in	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35605	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01910	Continued From page 28 the driveway and would not wait for LALD/CNS-B to count the medications. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated upon disposition of medications, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *10/23/23*
Time: 10:30:00
Report: 1013231256

Food and Beverage Establishment Inspection Report

Location:
Living Grace Home Care
10253 Mississippi Boulevard
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0038483
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523006600
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

PAINT WAS PEELING ON THE KITCHEN CEILING. COMPLY WITH ABOVE RULE. DISCUSSED PAINTING THE CEILING AND FACILITY MAINTENANCE.

Comply By: 12/04/23

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Meat
Temperature: 1 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Turkey
Temperature: 37 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator S. Umlauf.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid laminate counter top, and a painted ceiling.

Food and Beverage Establishment Inspection Report

A two basin sink is located in the kitchen. One sink basin is designated for hand washing.

A residential dish machine is located in the kitchen. Requested staff test the dish machine and email a picture of the test kit.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, biohazard clean up, and food handling procedures.

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 1013231256 of 10/23/23.

Certified Food Protection Manager: Temitope Olowu

Certification Number: 117185 Expires: 05/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

George Olowu
Operator

Signed: JM

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us