Electronically Delivered

June 18, 2026

Licensee
Amazing Grace Care LLC
7988 Hallmark Way
Apple Valley, MN 55124

RE: Project Number(s) SL41490015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 19, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 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 Department of Health 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.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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: SL41490015-0 On May 18, 2026, through May 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were no residents; none receiving services under the Provisional 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 18, 2026, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for the licensee's only resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan addendum revised on April 3,	0 630		

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0 630	Continued From page 4 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, catheter care, transfers, wheeling, boot management, blood glucose monitoring, Libre Sensor Management, wound care, medication setup and medication administration. R1's IAPP dated December 17, 2025, indicated R1 was not susceptible to abuse by others in the home or community environment. The licensee failed to recognize R1 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize her abuse by others including other vulnerable adults. On May 18, 2026, at 2:26 p.m., house manager/licensed practical nurse (HM/LPN)-B stated R1 was considered a vulnerable adult and her IAPP should have indicated she was at risk to be abused. The licensee's Vulnerable Adult policy dated April 4, 2025, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. The plan shall contain: -an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults -the resident's risk of abusing other vulnerable adults -statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries were authenticated by the name and title of the person making the entry in for the licensee's only resident record (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, catheter care, transfers, wheeling, boot management, blood glucose monitoring, Libre Sensor Management, wound care, medication setup and medication administration.	0 690		

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0 690	Continued From page 6 R1's medication administration record (MAR) dated April 2026, included check marks and/or staff initials but lacked staff names/signature and credentials/title for all staff who documented medication administration for R1. R1's care tracking document dated April 2026, included check marks and/or staff initials but lacked staff names/signature and credentials/title for all staff who documented services completed for R1. R1's blood sugar report dated April 1, 2026, through April 13, 2026, included staff initials but lacked staff names/signature and credentials/title for staff who documented blood sugar results. R1's blood sugar report dated April 14, 2026, through April 22, 2026, lacked authentication of the person making the entry. On May 18, 2026, at 2:30 p.m., house manager/licensed practical nurse (HM/LPN)-B reviewed R1's MAR, care tracking document and blood sugar report and stated they did not include authentication by the person making the entry. The licensee's Clinical Records policy dated April 4, 2025, indicated all entries into the clinical record will be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		

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0 810	Continued From page 7	0 810		
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 by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 8 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2,	01320		

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01320	Continued From page 9 paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. 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 the licensee's only unlicensed personnel (ULP-D) to include all required content. 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-D was hired on August 28, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of training for the following topics: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family.	01320		

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01320	Continued From page 10 -understanding appropriate boundaries between staff and residents and the resident's family ULP-D's employee record lacked evidence of competency evaluation for the following topics: -standby assistance techniques and how to perform them On May 18, 2026, at 3:20 p.m., house manager/licensed practical nurse (HM/LPN)-B reviewed ULP-D's employee record and stated it lacked documentation of the training and competency evaluations as listed above. The licensee's Staff Competency policy dated April 4, 2025, indicated training and competency evaluation for all ULPs would include: -standby assistance techniques and how to perform them -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -understanding appropriate boundaries between staff and residents and the resident's family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:	01330		

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01330	Continued From page 11 (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. 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 the license's only unlicensed personnel (ULP-D) to include all required content. 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-D was hired on August 28, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of	01330		

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01330	Continued From page 12 training for the following topics: -range of motion ULP-D's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion On May 18, 2026, at 3:20 p.m., house manager/licensed practical nurse (HM/LPN)-B reviewed ULP-D's employee record and stated it lacked documentation of the training and competency evaluations as listed above. The licensee's Staff Competency policy dated April 4, 2025, indicated training and competency evaluation for all ULPs would include: -safe transfer techniques and ambulation -range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530		

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	41490	A. BUILDING: _____ B. WING _____	05/19/2026

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01530	Continued From page 13 training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, and house manager/licensed practical nurse (HM/LPN)-B) received the required amount of dementia, mental illness, and de-escalation training in the required time frame.	01530		

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01530	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee provided services under a Provisional Assisted Living Facility license. ULP-D ULP-D was hired on August 28, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record contained evidence the employee received six hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-D's employee record contained evidence the employee received 1.25 hours of mental illness and de-escalation training, not the required two hours of training within 160 working hours of the employment start date. HM/LPN-B HM/LPN-B was hired on March 21, 2025, to provide direct care and services to the facility's residents. HM/LPN-B's record included a training transcript dated 2021, through 2026; however, these courses were completed at a different assisted living facility, not connected to the licensee. The	01530		

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01530	Continued From page 15 transcript contained evidence the employee received two hours of dementia training in 2024, two hours of dementia training in 2025 and two hours of dementia training in 2026. HM/LPN-B's record included a training transcript dated 2025, from the licensee; however, it lacked evidence of completing any dementia care training. HM-LPN-B's record lacked evidence of completing the required eight hours of training within 120 working hours of the employment start date and the required two hours of annual training for 2026. On May 18, 2026, at 3:18 p.m., HM/LPN-B reviewed ULP-D and her own training transcripts and stated ULP-D had not completed the required eight hours of initial dementia care training or the required two hours of initial mental illness and de-escalation training. HM/LPN-B stated she thought she had met the required dementia care training requirements through her other employment but after review of her transcript, she stated she had not completed the required eight hours of initial dementia training or the two hours of annual training. The licensee's Education on Dementia policy dated April 4, 2025, indicated the following: -Supervisors of direct-care staff will have at least eight (8) hours of initial dementia care education within 120 working hours of employment start date. - Supervisor of direct-care staff must have at least two (2) hours of education related to dementia care for each twelve (12) months of employment thereafter. -Direct care employees must have completed at	01530		

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01530	Continued From page 16 least eight (8) hours of initial dementia care education within 160 hours of employment start date. The licensee's Education on Mental Illness and De-escalation policy dated April 4, 2025, indicated direct-care employees must have completed at least two (2) hours of initial mental illness and de-escalation training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse:	01620		

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01620	Continued From page 17 (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for the licensee's only resident (R1). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, catheter care, transfers, wheeling, boot management, blood glucose monitoring, Libre Sensor Management, wound care, medication setup and medication administration. R1's assessments dated December 17, 2025, December 30, 2025, December 31, 2025, January 27, 2026, and March 17, 2026, were reviewed. R1's assessment dated March 17, 2026, did not include the required areas of the comprehensive assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659. On May 18, 2026, at 2:30 p.m., house manager/licensed practical nurse (HM/LPN)-B stated the March 17, 2026, assessment was a new assessment form the licensee implemented as a condensed version of the comprehensive assessment. HM/LPN-B stated the condensed assessment did not include all required areas of the uniform assessment.	01620		

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01620	Continued From page 19 The licensee's Comprehensive Nursing Assessment policy dated April 4, 2025, indicated the nurse will conduct and document a comprehensive assessment for all residents admitting to the licensee to determine the services required and to develop and individualized care plan for staff to implement. The assessment addresses the resident's physical, mental and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 20 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, catheter care, transfers, wheeling, boot management, blood glucose monitoring, Libre Sensor Management, wound care, medication setup and medication administration. The service plan was signed by the licensee; however, it was not signed by R1. R1's care tracking document dated April 2026, included the following service: -Passive Range of Motion (PROM) Assistance: perform passive range of motion twice a day as	01640		

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01640	Continued From page 21 tolerated for hand strength. Instructions on the wall in resident's room. R1's record lacked documentation of medication setup. On May 18, 2026, 2:36 p.m., house manager/licensed practical nurse (HM/LPN)-B reviewed R1's service plan and stated it should have included PROM exercises. HM/LPN-B stated R1 did not have medication setup services. HM/LPN-B stated she did not think R1 had to sign the service plan with small revisions/changes in services. The licensee's Service Plan policy dated April 4, 2025, indicated the following: -the service plan must be revised, if needed, based on resident review or reassessment -the initial service plan and any revisions are signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 22 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	01730		

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01730	Continued From page 23 Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for the licensee's only resident (R1) with insulin. 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 18, 2026, at approximately 9:40 a.m., house manager/licensed practical nurse (HM/LPN)-B stated the licensee provided medication management services. HM/LPN-B stated the licensee stored medication in a locked file cabinet, and a refrigerator. R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated April 2026, included the following orders: -Insulin aspart 100 units/milliliter (ml); Inject 35 units subcutaneously three times daily before meals -Insulin NPH 100 units/ml; Inject 100 units	01730		

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01730	Continued From page 24 subcutaneously in the morning with breakfast. If resident does not consume breakfast meal, then only administer 50 units in the morning. -Insulin NPH 100 units/ml; inject 55 units subcutaneously at bedtime R1's Medication Management Plan dated December 17, 2025, indicated medications were stored in a locked cabinet in the kitchen. R1's medication management plan lacked the following required content: -central storage refrigeration for insulin On May 18, 2026, at 2:44 p.m., HM/LPN-B reviewed R1's medication management plan and stated it did not include refrigeration storage for R1's insulin. The licensee's Service Plan for Medication Management policy dated April 4, 2025, indicated the licensee will prepare and document a medication management plan as part of the service plan for each resident receiving medication management services. The written medication management plan would include a description of the storage of medications based on the resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 25 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for the licensee's only resident (R1) for medication administration delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include and medication administration.	01750		

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01750	Continued From page 26 BLOOD SUGAR R1's signed prescriber orders dated April 6, 2026, included the following order: -glucose 40% gel; give 37.5 milliliters (ml) (15 milligrams (mg) of glucose) R1's as needed (PRN) medication administration record (MAR) dated April 2026, included the following order: -glucose 40% gel; take 37.5 ml (15 mg of glucose) by mouth as needed for hypoglycemia (low blood sugar) The licensee failed to have resident-specific instructions regarding what blood sugar result was considered a low blood sugar and would indicate administering glucose to R1. PAIN R1's MAR dated April 2026, included the following PRN medications for pain: -acetaminophen 500 mg; take two tablets by mouth every six hours as needed for pain -Lidocaine 4% patch; apply and remove patch (pain) -Diclofenac 1% gel; apply two grams to skin daily as needed (pain) -methocarbamol 500 mg; take one tablet by mouth three times a day as needed for pain The licensee failed to provide instructions for ULP to understand which PRN medication for pain should be used in which order. CONSTIPATION R1's MAR dated April 2026, included the following PRN medications for constipation: -lactulose 10 grams/15 ml; take 30 ml by mouth two times daily as needed for constipation	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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
01750	Continued From page 27 -milk of magnesia 400 mg/ml; take 30 ml by mouth daily as needed for constipation -Miralax 17 grams; daily as needed for constipation -sodium phosphate 7-19 gram enema; insert enema rectally once as needed for constipation The licensee failed to provide instructions for ULP to understand which PRN medication for constipation should be used in which order. On May 18, 2026, at 2:59 p.m., house manager/licensed practical nurse (HM/LPN)-B stated there were no written instructions regarding which PRN medications should be given in which order for R1's PRN medications for pain and constipation. HM/LPN-B stated R1's order for glucose did not indicate what blood sugar result would indicate administering the glucose. The licensee's Medication Administration policy dated April 4, 2025, indicated the registered nurse has prepared written instructions for the staff in the proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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
01760	Continued From page 28 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as ordered for the licensee's only resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include medication administration. BISACODYL SUPPOSITORY	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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
01760	Continued From page 29 R1's signed prescriber orders dated April 6, 2026, included bisacodyl 10 milligrams (mg); insert one suppository rectally daily. Use daily as needed until normal bowel movements are achieved. R1's medication administration record (MAR) dated April 2026, did not include the bisacodyl order. DICLOFENC GEL R1's MAR dated April 2026, included the following: -diclofenac 1% gel; apply two grams to skin daily as needed. The order did not include an indication for use LIDOCAINE PATCH R1's signed prescriber orders dated April 6, 2026, included the following order: -Lidocaine 4% patch; apply one patch to skin daily as needed. Leave on for up to 12 hours in a 24-hour period, then remove R1's MAR dated April 2026, included the following: -Lidocaine 4% Patch; apply/remove patch. The order did not include specific directions for use (remove after 12 hours), and reason for use (pain) On May 18, 2026, at 3:00 p.m., house manager/licensed practical nurse (HM/LPN)-B stated reviewed R1's MAR and stated the diclofenac gel order did not include indication for use which was for pain. HM/LPN-B stated the Lidocaine patch order did not include specific directions for use or indication for use (pain). HM/LPN-B stated she thought the bisacodyl order	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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
01760	Continued From page 30 was on R1's PRN MAR; however upon review, it was not listed. The licensee's Prescriber's Order policy dated April 4, 2025, indicated medication orders will include the name of the medication, dosage, and direction for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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
01820	Continued From page 31 The findings include: R1 was admitted on December 17, 2025, with diagnoses that included diabetes and borderline personality disorder. R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include and medication administration. R1's medication administration record (MAR) dated April 2026, included the following medications: -Refresh Tears 15 milliliter (ml); Instill one drop into both eyes four times daily (dry eyes) -cholecalciferol 50 micrograms (mcg); take one tablet by mouth daily (supplement) R1's record lacked signed prescriber orders for Refresh eye drops and cholecalciferol. On May 18, 2026, at 3:07 p.m., house manager/licensed practical nurse (HM/LPN)-B reviewed R1's record and could not locate prescriber orders for Refresh eye drops or cholecalciferol.. The licensee's Prescriber's Order dated April 4, 2025, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

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01940	Continued From page 32	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for the licensee's only	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

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01940	Continued From page 33 resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include boot management, blood glucose monitoring, Libre Sensor Management, wound care. The service plan did not include range of motion services. R1's Treatment Plan dated April 6, 2026, indicated R1 received treatment services to include: -Glucose Monitoring -Wound Care Protocol (left hand and right foot) -Physical and Maintenance Care (range of motion) R1's care tracking document dated April 2026, indicated staff assisted with boot on leg; put on in the morning and remove at bedtime R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided (Libre sensor changes and offloading orthopedic foot boot) On May 18, 2026, at 2: 52 p.m., house	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

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01940	Continued From page 34 manager/licensed practical nurse (HM/LPN)-B reviewed R1's treatment plan and stated it did not include Libre sensor management which included changing every two weeks and R1's orthopedic foot boot. The licensee's Treatment and Therapy Management policy dated April 4, 2025, indicated the registered nurse will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: -type of service to be provided -procedures for documenting treatments or therapies -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions -identification of treatment or therapy tasks delegated to unlicensed personnel -procedures for notifying the RN when a problem arises related to the treatment or therapy services No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	05/19/2026

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01970	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's only resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan addendum revised on April 3, 2026, indicated R1 received services to include boot management, blood glucose monitoring, Libre Sensor Management, and wound care. The service plan did not include range of motion services. R1's care tracking document dated April 2026, indicated staff assisted with boot on leg; put on in the morning and remove at bedtime R1's blood sugar report dated April 2026, indicated the staff checked R1's blood sugar three times a day. R1's record lacked documentation of Libre Sensor changes. R1's record lacked prescriber orders for three times a day blood sugar checks, Libre sensor	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 36 changes and orthopedic foot boot. On May 18, 2026, at 2:53 p.m., house manager/licensed practical nurse (HM/LPN)-B stated R1 was prescribed the orthopedic boot prior to her admission to the licensee and they did not have current orders for it. HM/LPN-B reviewed R1's orders and stated it lacked prescriber orders for three times a day blood sugar checks and Libre sensor changes. The licensee's Treatment and Therapy Management policy dated April 4, 2025, indicated the registered nurse (RN) or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. resident name b. description of the treatment or therapy to be provided c. frequency d. other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

DEPARTMENT OF HEALTH

, MN
Phone:

Food & Beverage Inspection Report

Establishment Info

Amazing Grace Care LLC
7988 HALLMARK WAY
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 41490

Risk:
License:
Expires on:
CFPM: Tsegereda Cherinat
CFPM #: 55363; Exp: 12/16/2027

Inspection Info

Report Number: F1068261004
Inspection Type: Full - Joint
Date: 5/18/2026 Time: 2:01:50 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-203.12 *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.
COMMENT: REFRIGERATOR INTERNAL THERMOMETER READ 33 DEGREES F. INSPECTOR'S THERMOCOUPLE MEASURED REFRIGERATOR AMBIENT AIR TEMPERATURE AT 43 - 44 DEGREES F. REPLACE REFRIGERATOR INTERNAL THERMOMETER.
Comply By: 5/18/2026 Originally Issued On: 5/18/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: NO SMALL DIAMETER PROBE THERMOMETER PRESENT.
Comply By: 5/18/2026 Originally Issued On: 5/18/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: REFRIGERATOR AMBIENT AIR TEMPERATURE OBSERVED AT 43 - 44 DEGREES F. NO TCS FOODS STORED IN REFRIGERATOR AT TIME OF INSPECTION. PERSON IN CHARGE TURNED THE REFRIGERATOR TEMPERATURE DOWN DURING THE INSPECTION.
Comply By: 5/18/2026 Originally Issued On: 5/18/2026

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) AND GABE STARK (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

THE ESTABLISHMENT DID NOT HAVE ANY RESIDENTS AT TIME OF INSPECTION.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-PREVENTING BAREHAND CONTACT
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS

-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES (SAME-DAY SERVICE ONLY)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE AND WITH THE NURSE EVALUATOR ON SITE AT THE CONCLUSION OF THE INSPECTION.

*FLOORS ARE TILE, WALLS ARE SMOOTH PAINTED DRYWALL WITH TILE BACKSPLASH, AND CEILING IS SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*KITCHEN HAS RESIDENTIAL GRADE EQUIPMENT. ALL FOOD MUST BE PREPARED AND SERVED SAME-DAY.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number F1068261004 from 5/18/2026

Tsegereda Cherinat
Person in charge

Gabriel Stark

Gabe Stark,
Public Health Sanitarian 2
gabe.stark@state.mn.us

, MN

DEPARTMENT OF HEALTH

Temperature Observations/Recordings

Establishment Info

Amazing Grace Care LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1068261004
Inspection Type: Full
Date: 5/18/2026
Time: 2:01:50 PM

Equipment Temperature: Product/Item/Unit: Ambient Air**; Temperature Process:** Ambient Air
Location: Refrigerator at 43 Degrees F.
Comment: Refrigerator turned down during inspection.
Violation Issued?: No

, MN

DEPARTMENT OF HEALTH

Sanitizer Observations/Recordings

Establishment Info

Amazing Grace Care LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1068261004
Inspection Type: Full
Date: 5/18/2026
Time: 2:01:50 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41490015-0	**Date:** May 19, 2026
Facility Name: AMAZING GRACE CARE LLC	
Facility Address: 7988 HALLMARK WAY, Apple Valley, MN 55124	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The house manager/licensed practical nurse, (HM/LPN)-B lacked documentation that showed training was provided to employees on the FSEP upon hire and at least twice per year. HM/LPN-B stated they only did verbal training during fire drills.

4. 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. [Minn. Stat. 144G.45 subd.2]

Comments: The house manager/licensed practical nurse, (HM/LPN)-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.