DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 26, 2022

Administrator
Grace Assisted Living, LLC
2566 112th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL35793015

Dear Administrator:

On August 18, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 7, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered

July 21, 2022

Administrator
Grace Assisted Living, LLC
2566 112th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL35793015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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 Department of Health within 15 business days of the correction order receipt date. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35793	A. BUILDING: _____ B. WING _____	06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	2566 112TH AVENUE NW 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 Initial comments On June 7, 2022, the immediacy of correction order 1290 has been removed, however non-compliance remains at a scope and level of I. ******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: SL37973015 On June 6, 2022, through June 7, 2022, 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) residents, receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems 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 June 6, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-C stated the licensee's	0 250		

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0 250	Continued From page 3	0 250		

employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.

The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:

- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.

- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.

- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.

- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.

- Reporting of Maltreatment of Vulnerable Adults.

- Electronic Monitoring in Certain Facilities.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone

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0 250	Continued From page 4	0 250		

conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-C on May 10, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On June 6, 2022, at approximately 9:40 a.m., LALD-C confirmed the licensee provided medication and treatment management, conducted and documented appropriate tuberculosis (TB) screenings, and supervised unlicensed personnel performing delegated tasks, but failed to develop corresponding policies	0 250		

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0 250	Continued From page 6 and procedures, as required. As a result of this survey, the following orders were issued; 0430, 0450, 0470, 0480, 0490, 0550, 0570, 0630, 0650, 0660, 0680, 0730, 0780, 0790, 0810, 0900, 1290, 1620, 1650, 1690, 1710, 1760, 1770, 1820, 1890, 1910, 1940, 1970, and 2240, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided	0 430		

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0 430	Continued From page 7 under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) to one of one resident (R1) with record reviewed. 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: R1 was admitted to the licensee on June 22, 2020, under the comprehensive license and started receiving assisted living services on August 1, 2021. R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration, treatments, bathing assistance, walker assistance, and transportation for medical appointment. R1's record lacked a UDALSA checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist of all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted	0 430		

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0 430	Continued From page 8 living facility contract, and identifying all services allowed under the license that the facility does not provide. On June 7, 2022, at approximately 10:40 a.m., licensed assisted living director (LALD)-C acknowledged R1 and all other residents who received services under the assisted living license had not received a written checklist that listed all services provided under the licensee's assisted living license, and the services not provided under the licensee's assisted living license. LALD-C also stated the license had just received the forms and the residents will be signing them. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced	0 450		

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0 450	Continued From page 9 by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to three of three residents (R1, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 was admitted on June 22, 2020. R3 was admitted on July 8, 2021. R4 was admitted on June 25, 2021. R1, R3, and R4's records lacked the current assisted living BOR. On June 7, 2022, at approximately 12:10 p.m., registered nurse (RN)-A acknowledged the residents' records were missing current BOR. RN-A stated maybe the records were not complete and he would investigate further. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 10 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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	35793	A. BUILDING: _____ B. WING _____	06/07/2022

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0 470	Continued From page 11 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-C identified registered nurse (RN)-A as the licensee's clinical nurse supervisor. On June 6, 2022, at approximately 10:10 a.m., during the facility tour surveyor observed staffing plan was not posted. On June 7, 2022, at approximately 12:00 p.m., RN-A and LALD-C acknowledged the licensee had not developed a staffing plan and stated the licensee was not aware of the requirement for a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA)	0 480		

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0 480	Continued From page 12 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents of 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated June 6, 2022. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 485	Continued From page 13	0 485		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all two residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 485		

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0 485	Continued From page 14 the residents). The findings include: On June 6, 2022, at approximately 9:40 a.m., during entrance conference, the surveyor requested the week's meal menu. Licensed assisted living director (LALD)-C pointed to a posted document with the days of the week (Monday through Sunday), but the document did not have dates on it. On June 6, 2022, at approximately 10:45 a.m., LALD-C acknowledged the posted document served as the menu. LALD-C stated it did not have dates on it, and it lacked to show the menu at least one week in advance. The licensee's Policy and Procedure Requirements dated July 2021, indicated menus were made a week ahead and made available but did not include verbiage. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for	0 490		

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0 490	Continued From page 15 providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for two of two residents (R1, R3) with records reviewed. 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 June 22, 2020.	0 490		

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0 490	Continued From page 16 R3 was admitted on July 8, 2021. On June 6, 2022, at approximately 9:50 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee provided planned social and recreational activities for the residents throughout the day. During observations on June 6 and 7, 2022, the surveyor observed no activities planned or offered to the residents by the licensee. On June 6, 2022, at approximately 11:30 a.m., the surveyor observed R1 in the living area of the assisted living watching television, and R3 remained in her room throughout the day and only came out when unlicensed personnel (ULP)-B administered her medications. On June 6, 2022, at approximately 12:10 p.m., ULP-B stated R3 liked to remain her room most of time. When asked about if the residents had activities during the day, ULP-B stated sometimes they go for walks. During an interview on June 7, 2022, at approximately 12:20 p.m., house supervisor (HS)-D acknowledged the licensee had not implemented a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		

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0 550	Continued From page 17	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors and all four residents receiving assisted living 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

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0 550	Continued From page 18 On June 6, 2022, at approximately 10:50 a.m., during the facility tour, the surveyor did not observe a posting of the above required content in a conspicuous place. On June 6, 2022, at approximately 1:20 p.m., licensed assisted living director (LALD)-C acknowledged the posting was missing as required and stated the licensee will ensure it is posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. 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).	0 570		

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0 570	Continued From page 19 The findings include: During a facility tour on June 6, 2022, at approximately 10:30 a.m., the surveyor did not observe a posting of the original current license at the facility's main entrance. On June 6, 2022, at 10:27 a.m., licensed assisted living director (LALD)-C verified the license was not posted in the establishment's main entrance. LALD-C stated he will make a copy for posting in the main entrance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=D	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	0 630		

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0 630	Continued From page 20 statements of the specific measures to be taken to minimize the risk of abuse for one of four residents (R1) with records reviewed. 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: R1 was admitted on June 22, 2020. R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration, treatments, bathing assistance, walker assistance, and transportation for medical appointment. R1's IAPP dated June 22, 2020, lacked specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 7, 2022, at approximately 10:30 a.m., registered nurse (RN)-A acknowledged R1's abuse prevention plan lacked specific measures to minimize abuse. RN-A also stated the IAPP will be updated to reflect required specific measures. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 21	0 650		
0 650 SS=D	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 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (unlicensed personnel	0 650		

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0 650	Continued From page 22 (ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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: ULP-B had a hire date of April 8, 2022. On June 6-7, 2022, ULP-B provided assisted living services to include medication administration and insulin set up for the licensee's residents. ULP-B's employee record lacked evidence of supervision by the registered nurse (RN) within 30 days of performing delegated tasks. On June 7, 2022, at approximately 3:55 p.m., licensed assisted living director (LALD)-C acknowledged ULP-B's employee record was missing supervision within 30 days of performing delegated tasks and stated the licensee will implement the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 23 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B) completed a TB history and symptom screen and baseline TB screening at date of hire. 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	0 660		

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0 660	Continued From page 24 situation has occurred only occasionally). The findings include: The licensee's TB facility risk assessment dated May 1, 2022, was noted as low risk. ULP-B started employment with the licensee on April 8, 2022. ULP-B's record lacked evidence of a completed TB history and symptom screen and baseline TB screening at date of hire. On June 7, 2022, at approximately 11:25 a.m., registered nurse (RN)-A acknowledged ULP-B's record was lacking a TB history and symptom screen and baseline TB screening at date of hire. RN-A stated she was not aware as she had also started employment with the licensee around the same time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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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
0 680	Continued From page 25 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a written emergency disaster plan with all required content and post the emergency plan prominently. This had the potential to affect all current residents receiving services under the assisted living license, staff, and visitors to 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:	0 680		

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	35793	A. BUILDING: _____ B. WING _____	06/07/2022

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0 680	Continued From page 26 On June 6, 2022, at approximately 9:50 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency disaster preparedness plan. On June 6, 2022, at approximately 10:15 a.m., during the facility tour surveyor observed the emergency disaster plan was not posted. The licensee's plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for	0 680		

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0 680	Continued From page 27 communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements On June 6, 2022, at approximately 3:00 p.m., licensed assisted living director (LALD)-C acknowledged the licensee was missing required content in emergency disaster plan, and stated the licensee was working with a consultant to come up with one. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of	0 730		

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0 730	Continued From page 28 the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	0 730		

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0 730	Continued From page 29 Based on interview and record review, the licensee failed to complete a discharge summary for one of one discharged resident (R2) with record reviewed. 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: R2 was discharged from licensee on February 25, 2022. R2's record lacked a discharge summary. On June 7, 2022, at approximately 11:40 a.m., registered nurse (RN)-A verified R2's record lacked a discharge summary. RN-A stated the licensee will update R2's record to reflect the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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:	0 780		

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0 780	Continued From page 30 (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 smoke alarms that are interconnected throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 780		

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0 780	Continued From page 31 Findings include: 1) During the facility tour on June 06, 2022, at approximately 11:40 a.m. with the Facility Supervisor (S)-D, it was observed that the smoke alarms throughout the entire facility were not interconnected so that the actuation of one would cause all alarms to operate. 2) During the facility tour on June 06, 2022, between 11:15 a.m. and 12:20 p.m. with the Facility Supervisor (S)-D, it was observed that multiple smoke detectors throughout the residence we out of date in the bedrooms and hallways. 3) During the facility tour on June 06, 2022, between 11:15 a.m. and 12:20 p.m. with the Facility Supervisor (S)-D, an improperly installed and out of date smoke detector was observed in the back corner of room 1. Facility Supervisor(S)-D verbally confirmed survey staff observations during the facility tour. 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 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	0 790		

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0 790	Continued From page 32 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 maintain fire extinguishers in accordance with the MN State Fire Code. This had the potential to affect all current 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: 1) During the facility tour on June 06, 2022, at approximately 11:40 a.m. with the Facility Supervisor (S)-D, it was observed that the fire extinguisher located in the kitchen was the incorrect size (1-A:10-B:C). 2) During the facility tour on June 06, 2022, at approximately 11:40 a.m. with the Facility Supervisor (S)-D, it was observed the correct size Fire Extinguisher in the basement did not have a tag on it showing it had been inspected as required by MN State Fire Code. Monthly inspections were being marked as done on a sheet above the Fire Extinguisher as being completed. During an interview with the Facility Supervisor (S)-D, survey staff informed the	0 790		

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0 790	Continued From page 33 current marking system does not comply with the MN State Fire Code. Facility Supervisor(S)-D verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 34 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). On June 06, 2022, between 11:15 a.m. and 12:20 p.m., survey staff toured the facility with the Facility Supervisor (S)-D. During the facility tour, it was observed that evacuation maps were not provided in the facility. On June 06, 2022, at approximately 11:30 a.m., the Facility Supervisor (S)-D provided limited documents for review. Documents were reviewed by survey staff on June 06, 2022, between 11:15 and 12:20 p.m. 1. Evacuation maps were not available at the time of the survey.	0 810		

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0 810	Continued From page 35 2. The off-site evacuation location was said to be an off-site home that they have an agreement with. The agreement was not observed during record review. 3. The licensee failed to provide unique or unusual resident needs for movement or evacuation. 4. The licensee failed to provide employee training logs for fire safety and evacuation. 5. The licensee failed to provide the required employee training frequency. 6. The licensee failed to provide annual fire safety and evacuation training for residents. 7. Training documentation was requested by survey staff but not provided. 8. Multiple fire drill reports were provided for review at the time of the survey. The documentation provided had a date, time and 4 names on them. No other content was provided regarding the fire drill. Facility Supervisor(S)-D verbally confirmed survey staff observations during the facility tour. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 36 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for three of three residents (R1, R3, R4) with records reviewed. 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	0 900		

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0 900	Continued From page 37 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 June 22, 2020. R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration, treatments, bathing assistance, walker assistance, and transportation for medical appointment. R3 was admitted on July 8, 2021. R3's Service Plan dated January 21, 2022, indicated R3 received services to include medication administration and reminders, treatments, bathing assistance, walker assistance, hygiene/grooming reminders, laundry, housekeeping, and food preparation. R4 was admitted on June 25, 2021. R4's Service Plan dated June 25, 2021, indicated R4 received services to include medication administration and reminders, treatments, bathing assistance, walker assistance, hygiene/grooming reminders, laundry, housekeeping, dressing, continence assistance, and food preparation. R1, R3, and R4's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing	0 900		

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0 900	Continued From page 38 (2) assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and (3) the resident's service plan, if applicable. On June 6, 2022, at approximately 3:40 p.m., licensed assisted living director (LALD)-C acknowledged the residents' records were missing a contract, and stated the licensee was working with a consultant to finalize the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a	01290	Minnesota Department of Health is documenting the State Licensing	

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01290	Continued From page 39 background study was conducted prior to staff providing services for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B) with records reviewed. 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 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: RN-A had a hire date of April 4, 2022. RN-A's employee record lacked evidence of a background clearance as required. On June 7, 2022, at approximately 12:20 p.m., licensed assisted living director (LALD)-C verified RN-A's record lacked a background study clearance. LALD-C indicated it had been difficult to find fingerprinting appointments. On June 7, 2022, at approximately 12:35 p.m., LALD-C attempted to verify RN-A's background clearance on the Department of Health and Human Services (DHS) website and was only able to verify RN-A's background study was affiliated on June 1, 2022, and RN-A required supervision while working with licensee's residents. LALD-C further stated RN-A had a fingerprint appointment for June 9, 2022. On June 7, 2022, at approximately 12:40 p.m., DHS Netstudy 2.0 website stated RN-A was affiliated to licensee as a licensed practical nurse	01290	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.	

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01290	Continued From page 40 on March 30, 2022, and separated on April 14, 2022, and affiliated a second time to licensee on May 14, 2022, and separated on May 29, 2022. ULP-B had a hire date of April 8, 2022. ULP-B's employee record lacked evidence of a background clearance as required. On June 7, 2022, at approximately 1:20 p.m., LALD-C verified ULP-B's record lacked a background study clearance. LALD-C attempted to verify ULP-B's background clearance on the DHS website but was not able to verify that it was complete. LALD-C again stated it was hard to have fingerprinting completed as licensee could not secure an appointment. On June 7, 2022, at approximately 1:30 p.m., LALD-C provided the surveyor with a completed appointment confirmation for fingerprinting dated May 14, 2022, and stated he had no idea why ULP-B's name was not pulling up in the licensee's net study account. On June 8, 2022, at approximately 1:34 p.m., DHS Netstudy 2.0 website stated ULP-B was affiliated to licensee on May 14, 2022, and separated on May 29, 2022. The licensee's Background Checks policy, undated, indicated employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01290		

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01290	Continued From page 41 Immediacy is removed as confirmed by email and conversation with evaluation supervisor on June 7, 2022, however noncompliance remains at a scope and severity of I.	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and	01620		

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01620	Continued From page 42	01620		

reassessment to include all areas required on the uniform assessment tool. In addition, the licensee failed to ensure the RN conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the date of the last assessment for one of three residents (R1) with records reviewed.

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 June 22, 2020.

R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration, treatments, bathing assistance, walker assistance, monitoring and reassessment and transportation for medical appointment.

R1's 90-day reassessment titled Comprehensive Home Care Monitoring and Reassessment lacked areas required on the uniform assessment tool including:
- the resident's personal lifestyle preferences,
- activities of daily living,
- instrumental activities of daily living,
- physical health status,
- emotional and mental health conditions,
- cognition,
- communication and sensory capabilities,
- pain,

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01620	Continued From page 43 - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators, - who has decision-making authority for the resident, and - the need for follow-up referrals for additional medical or cognitive care by health professionals. R1's record included documentation of nursing assessments completed on July 14, 2021, October 14, 2021, and January 14, 2022, all the assessments were two days off 90 days. On June 7, 2022, at approximately 12:10 p.m., RN-A acknowledged the licensee's assessments did not use the uniform assessment tool, and the nursing assessment completed were over the required 90 days. In addition, RN-A stated the assessments were completed by another RN. RN-A also stated the same assessment tool was used for all the licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 44 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all the required content for three of three residents (R1, R2, R4) with records reviewed. 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	01650		

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01650	Continued From page 45 a large portion or all of the residents). The findings include: R1 was admitted on June 22, 2020. R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration, treatments, bathing assistance, walker assistance, monitoring and reassessment and transportation for medical appointment. R1's service plan lacked the content to include: - the fees for services; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 was admitted on August 14, 2020. R2's Service Plan dated January 16, 2021, indicated R2 received services to include medication administration, treatments, bathing assistance, walker assistance, grooming, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R2's service plan lacked the content to include: - the fees for services; - the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 46 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 was admitted on June 25, 2021. R4's Service Plan dated June 25, 2021, indicated R4 received services to include medication administration, treatments, bathing assistance, continence assistance, dressing assistance, grooming, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R4's service plan lacked the content to include: - the fees for services. On June 7, 2022, at approximately 3:20 p.m., licensed assisted living director (LALD)-C acknowledged the residents' service plans were missing required content, and stated the licensee will update all residents' service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management	01690		

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01690	Continued From page 47 services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.	01690		

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01690	Continued From page 48 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-C confirmed the licensee provided medication management services to the licensee's residents. On June 7, 2022, at approximately 7:10 a.m., unlicensed personnel (ULP)-B administered morning medications to R3 and R4. On June 7, 2022, at approximately 2:40 p.m., LALD-C emailed the surveyor a document titled The Essential Guide Assisted Living in Minnesota dated July 2021. The document contained samples of regulations and required clinical policies/procedures, but none were customized to licensee's operations. On June 7, 2022, at approximately 2:55 p.m., LALD-C stated the document provided was in progress to develop their policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		

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01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for one of one resident (R1) with record reviewed. 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: R1's diagnosis included dementia (group of symptoms that affects memory, thinking and interferes with daily life). R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated June 2022, indicated R1 was receiving	01710		

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01710	Continued From page 50 aspirin 81 milligram (mg) tablet once daily, omeprazole 20 mg capsule daily, metoprolol 50 mg one tablet twice daily and acetaminophen 500 mg tablet every four hours as needed for pain. R1's record lacked monitoring and reassessment of medication management services at least annually for the following: - documentation the assessment was conducted face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and - identification of interventions needed in management of medications. On June 7, 2022, at approximately 11:13 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged R1's record lacked monitoring and reassessment of medication management services annually as required for the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	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 administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 51	01760		

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 observation, interview, and record review, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for one of one resident (R3) with record reviewed.

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:

R3 was admitted on July 8, 2021.

R3's diagnoses included anxiety, and bipolar disorder (serious mental illness characterized by extreme mood swings).

R3's service plan dated July 8, 2021, indicated R3 received medication management.

R3's medication administration record (MAR) dated June 2022, indicated R3 was receiving

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01760	Continued From page 52 suboxone 8-2 milligram (mg) film sublingually once daily, venlafaxine 150 mg extended release (ER) capsule once daily, ziprasidone 60 mg capsule twice daily, topiramate 100 mg tablet twice daily, olanzapine 20 mg tablet at bedtime, trazodone 100 mg tablet at bedtime, clonazepam 1 mg tablet three time daily as needed and diclofenac 75 mg DR tablets twice daily as needed. On June 7, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B administered medications to R3 including clonazepam 1 mg tablet three time daily as needed. On June 7, 2022, at approximately 10:35 a.m., registered nurse (RN)-A acknowledged ULP-B did not document the medication administration or the effectiveness. RN-A also stated all PRN medications should have documentation of effectiveness for every dose administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01770		

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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
01770	Continued From page 53	01770		

review, the licensee failed to ensure documentation of medication setup included all the required content for one of two residents (R1) with records reviewed.

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:

During the entrance conference on June 6, 2022, at approximately 9:45 a.m., licensed assisted living director (LALD)-C stated the licensee provided medication management services which included medication setup by the registered nurse (RN) for their residents.

R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration.

R1's medication administration record (MAR) dated June 2022, indicated R1 was receiving aspirin 81 milligram (mg) tablet once daily, omeprazole 20 mg capsule daily, metoprolol 50 mg one tablet twice daily and acetaminophen 500 mg tablet every four hours as needed for pain.

On June 7, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-B dispensed medications from a preset-up pillbox for R1.

R1's record lacked documentation of dates of

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	35793	A. BUILDING: _____ B. WING _____	06/07/2022

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GRACE ASSISTED LIVING LLC	2566 112TH AVENUE NW COON RAPIDS, MN 55433

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01770	Continued From page 54 medication setup, name of medications, quantities of dose, times to be administered, routes of administration, and the name of person completing medication setup done at the time of setup. On June 7, 2022, at approximately 12:45 p.m., RN-A acknowledged R1's record was missing documentation of medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	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 written or electronically recorded prescriptions were obtained for one of one resident (R4) with record reviewed. 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).	01820		

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01820	Continued From page 55 The findings include: During the entrance conference on June 6, 2022, at approximately 9:45 a.m., licensed assisted living director (LALD)-C stated the licensee provided medication management services which included medication setup by the registered nurse (RN) for their residents. R4's Service Plan dated June 25, 2021, indicated R4 received services to include medication administration. R4's medication administration record (MAR dated June 2022, indicated R4 was receiving aspirin 81 milligram (mg) tablet once daily, Jardiance 25 mg tablet once daily, omeprazole 20 mg capsule once daily, risperidone 4 mg tablet every morning, urea 20 cream apply topically, Victoza 18 mg/3 milliliter (ml) inject 1.8 mg subcutaneously once daily, vitamin B-1 100 mg tablet once daily, novolog flexpen 100 units/ml 15 ml inject 5 units subcutaneously three times daily with meals, metformin 500 mg two tablet twice daily with meals, clobetasol solution 0.05% apply twice topically, propranolol 20 mg tablet twice daily, atorvastatin 40 mg tablet once daily, basaglar 100 units/ml kwikpen inject 34 units subcutaneously once daily, melatonin 5 mg tablet at bedtime, and risperidone 3 mg tablet take two tablets at bedtime. On June 7, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-B administered medications to R4. R4's record lacked current written or electronically recorded prescriptions for all medications that the licensee was managing for R4.	01820		

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01820	Continued From page 56 On June 7, 2022, at approximately 2:35 p.m., RN-A acknowledged R4's record was missing current prescriber orders and stated the licensee will call the clinic for the orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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: Based on observation, interview record review, the licensee failed to dispose of expired medications and ensure medications were labeled correctly for one of three residents (R1) with records reviewed. 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).	01890		

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01890	Continued From page 57 The findings include: R1's Service Plan dated April 9, 2021, indicated R1 received services to include medication administration. On June 6, 2022, at approximately 12:36 p.m., the surveyor reviewed medication storage area and the following was observed: Expired medications - gavilax polyethylene 3350 expired on April 22, 2022 - clopidogrel 75 milligram (mg) tablets expired on March 31, 2022 - aspirin 81 mg tablets expired on March 31, 2022 - isosorbide mononitrate 30 mg extended release expired on March 31, 2022 - nitroglycerine 0.4 mg tablets expired on March 31, 2022 Unlabeled medications - multivitamin (dietary supplement) - glucosamine hcl + chondroitin sulphate sodium - triamcinolone acetonide lotion USP 0.1% - Tylenol 650 mg capsules On June 6, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-C acknowledged the medication storage findings and stated registered nurse (RN)-A will go through the storage area every so often to ensure all medications are current and labeled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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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, 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 provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one deceased resident (R2) with record reviewed. 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	01910		

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01910	Continued From page 59 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: R2 was discharged from the licensee on February 25, 2022. R2's Service Plan dated January 16, 2021, indicated R2 received services to include medication administration, treatments, bathing assistance, walker assistance, grooming, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R2's record lacked documentation of 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. On June 7, 2022, registered nurse (RN)-A acknowledged R2's record was missing the required content above and stated licensee was not aware of the statute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 60 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 observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R4) reviewed for treatments. This practice resulted in a level two violation (a	01940		

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01940	Continued From page 61 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: R4's diagnoses included diabetes mellitus, bipolar mood disorder, and psoriasis. R4's Service Plan dated June 25, 2021, indicated R4 received services to include treatments. On June 7, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B administered medications and setup insulin for R4. R4's undated Treatment/Therapy Management Plan indicated R4 was receiving blood glucose monitoring. R4's treatment and management plan lacked the content to include: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received. On June 7, 2022, at approximately 10:30 a.m.,	01940		

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01940	Continued From page 62 registered nurse (RN)-A acknowledged the content above was missing and stated the plan will be updated to reflect the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments. 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).	01970		

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01970	Continued From page 63 The findings include: During the entrance conference on June 6, 2022, at approximately 9:50 a.m., licensed assisted living director (LALD)-C confirmed the licensee provided treatment therapy services to residents. R4's diagnosis included diabetes mellitus. R4's Service Plan dated June 25, 2021, indicated R4 received services to include treatments. R4's Daily Blood Glucose Charting record dated May 1, 2022, through June 6, 2022, indicated the licensee was monitoring blood glucose for R4 up to four time per day (morning, pre-lunch, pre-dinner, and bedtime) On June 7, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-A setup equipment for blood glucose monitoring and insulin for R4 to self-administer. R4's record lacked orders for blood glucose monitoring. On June 7, 2022, at approximately 12:45 p.m., registered nurse (RN)-A acknowledged R4's record lacked prescriber's orders for the above treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification	02240		

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02240	Continued From page 64 (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the	02240		

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02240	Continued From page 65 assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the process for filing a complaint and a written acknowledgement received for the licensee's three current residents (R1, R3, R4) with records reviewed. 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: R1 was admitted on June 22, 2020. R3 was admitted on July 8, 2021. R4 was admitted on June 25, 2021. R1, R3, and R4's records lacked a signed acknowledgement they had received a process for filing a complaint. On June 7, 2022, at approximately 12:10 p.m., registered nurse (RN)-A acknowledged the residents' records were missing a signed acknowledgment that they had received a process for filing a complaint. No further information provided.	02240		

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02240	Continued From page 66 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/06/22*
Time: 13:00:00
Report: 1025221112

Food and Beverage Establishment Inspection Report

Location:
Grace Assisted Living Llc
2566 112th Avenue Nw
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0037537
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128881277
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

Ambient temperature in cooler between 39 deg F and 45 deg F. Maintain cold TCS foods at 41 deg F or below; verify using available food thermometer (clean and sanitized if used in food).

Comply By: 06/06/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Employ a CFPM at this establishment; post certificate when received.

Comply By: 06/06/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

Designate one compartment of the sink as the hand washing sink; signage provided during inspection.

Corrected on Site

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

Discussed employee illness, hygiene, illness reporting and exclusion. Food reported purchased from local area grocery and warehouse stores. Discussed MDA Food Recall website.

Kitchen has laminate counters. Provide an approved food contact surface for food preparation; cutting boards which are large enough to use comfortable but are still submersible for sanitizing are one option.

When replacing missing cabinet knobs, provide knobs that have a smooth surface (front and back) to facilitate cleaning and sanitizing.

Discussing Wash/Rinse/Sanitize process. The location has a dishwasher equipped with a residential sanitization cycle. The sanitize cycle is usually fairly long (~4 hours) and does not necessarily reach a contact temperature of 160 deg F. Discussed using the dishwasher for washing and rinsing dishes, and then providing an alternate compartment for sanitizing dishes and utensils in a bleach water (~1 tea per 1 gal of water, submerge 1 min, and air dry) or other appropriate chemical sanitizing solution. (4626.0680)
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

Discussed use of disinfecting wipes, cleaners, etc following label directions; generally, these are only safe for food contact surfaces when accompanied by a potable water rinse.

Reported that food is not cooled and leftovers not saved for the next day. To cool TCS foods for next-day service, 4626.0506 item A would apply.
(G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2)prepares TCS foods only for same-day service.)

Establishment had a food thermometer available; discussed using this to verify temperature within the available upright cooler (NSF Standards SS cooler). There was a temperature gradient in the cooler of approx. 39 deg F on the top shelf and 45 deg F on the bottom. Cold TCS food (perishables) should be stored at the top of the cooler where it is coldest (except for raw animal food/meat, which must always be stored below ready-to-eat food). Cooler may need service if the temperature gradient is persistent.

Discussed pest control, TCS food cooking temperatures, basement chest freezer storage (under an approved finish ceiling, move freezer if there is a leak of utilities above ceiling); personal items vs food and beverages provided by facility; medication storage (dedicated cooler locked in kitchen); 2 compartment sink usage (dedicate one to handwashing, the other to ware washing or food preparation); CFPM process.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025221112 of 06/06/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Kitessa

Signed:_____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221112

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	3	Date	06/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	13:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Grace Assisted Living Llc	Address: 2566 112th Avenue Nw	City/State: Coon Rapids, MN	Zip Code: 55433	Telephone: 6128881277
License/Permit #: 0037537	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 06/08/22

Inspector (Signature) Cory Kline