



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

September 16, 2025

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

RE: Project Number(s) SL24881016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

### **STATE CORRECTION ORDERS**

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

### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

**St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

#### **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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

Shepherd of Grace LLC

September 16, 2025

Page 3

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: [Kelly.Thorson@state.mn.us](mailto:Kelly.Thorson@state.mn.us)

Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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	<p><b>Initial Comments</b></p> <p><b>***ATTENTION***</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>SL24881016-0</b></p> <p>On July 28, 2025, through July 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 66 residents; 34 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 480 SS=F	<b>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</b>	0 480		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
0 480	<p>Continued From page 2</p> <p>allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	<p><b>144G.45 Subd. 2. (a) Fire protection and physical environment</b></p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents.</p> <p>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).</p> <p>The findings include:</p> <p>On July 29, 2025, the surveyor toured the facility with maintenance (M)-E and licensed assisted living director (LALD)-A. The following was observed.</p> <p>1. The fire rated doors at the following locations did not latch and seal.</p> <ul style="list-style-type: none"> <li>a. Cottages: fire door at the great room.</li> <li>b. Apartments: Fire door level 1 kitchen, and level 1 stairway B &amp; C doors. Swinging fire doors</li> </ul>	0 775		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
0 775	<p>Continued From page 4</p> <p>shall close from the full-open position and latch automatically.</p> <p>2. Trash chute door on the third floor did not self-close and positively latch. The door would stay in the open position until assisted to start closing. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system that connects all levels of the facility.</p> <p>During the facility tour, M-E, and LALD-A verified the above listed observations.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 775		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
0 810	<p>Continued From page 5</p> <p>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.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>On July 29, 2025, maintenance (M)-E and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>The findings include:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
0 810	<p>Continued From page 6</p> <p><b>FIRE SAFETY AND EVACUATION PLAN:</b> The licensee's FSEP failed to include the following:</p> <p>The FSEP included standard administrative responsibilities for fire safety but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. During the interview LALD-A stated staff shall direct residents needing assistance to an area of refuge and the fire department will assist with evacuating those residents. The policy indicated that staff should evacuate all residents.</p> <p>On July 29, 2025, LALD-A stated they understood the area of the policy that is incomplete and would work to bring the policy into compliance.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) days</p>	0 810		
01620 SS=F	<p><b>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</b></p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01620	<p>Continued From page 7</p> <p>conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p> <p>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>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 nursing assessments</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01620	<p>Continued From page 8</p> <p>not to exceed every 90-days for two of two residents (R1, R2).</p> <p>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)</p> <p>The findings include:</p> <p><b>R1</b> R1 admitted to the licensee and began receiving assisted living with dementia care services on August 7, 2024.</p> <p>R1's diagnoses included Alzheimer's disease.</p> <p>R1's Service Plan signed February 10, 2025, indicated R1 received assistance with bathing, grooming, housekeeping, laundry, medication administration, and toileting.</p> <p>R1's record included 90-day ongoing comprehensive assessments dated December 19, 2024, March 25, 2025, (96 days apart) and June 24, 2025 (91 days apart).</p> <p><b>R2</b> R2 admitted to the licensee and began receiving assisted living services on April 11, 2023.</p> <p>R2's diagnoses included type 2 diabetes.</p> <p>R2's Service plan, dated effective as of February 7, 2025, indicated R2s services included bathing,</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01620	<p>Continued From page 9</p> <p>diabetic monitoring, housekeeping, laundry, and medication administration,</p> <p>R2's record included 90-day ongoing comprehensive assessments February 5, 2024, and May 7, 2025, indicated 91 days had passed between assessments.</p> <p>On July 29, 2025, at 12:42 p.m., during interview with registered nurse (RN)-B; RN-B stated ongoing assessments were linked in their computer system for an alert in 90 days. RN-B stated they would adjust the timing in their computer system to ensure assessment would be done within 90 days.</p> <p>The licensee's 1-6 Initial and On-going Nursing Assessment of Resident policy dated August 2021, indicated nursing assessments were completed by a registered nurse with ongoing assessments to be completed periodically but no less than every 90-days.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01640	<p>Continued From page 10</p> <p>resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect current services provided for one of one resident (R4).</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the licensee and began receiving assisted living with dementia care services on August 7, 2024.</p> <p>R1's diagnoses included Alzheimer's disease.</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01640	<p>Continued From page 11</p> <p>R1's Service Plan signed February 10, 2025, indicated R1 received assistance with bathing, grooming, housekeeping, laundry, medication administration, and toileting.</p> <p>On July 28, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-D obtain R1's blood sugar.</p> <p>On July 29, 2025, at 8:45 a.m., the surveyor observed ULP-D obtain R1's blood sugar.</p> <p>R1's Clinical Update Assessment 90 day, dated June 24, 2025, indicated R1 received blood diabetic monitoring three times day.</p> <p>R1's Service Recap Summary for July 2025; indicated completed tasks for diabetic monitoring three times a day.</p> <p>On July 29, 2025, at 1:12 p.m. registered nurse (RN)-B stated, "I am not able to find R1's service plan with the addition of Diabetic monitoring."</p> <p>The licensee's 2-4 Contents of Service Plans policy dated August 2021, indicated service plans are reviewed and revised as needed based upon ongoing resident assessments. Residents will be notified of changes to fees for services when applicable.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) day</p>	01640		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
--------------------	--	---------------	---	--------------------

01890	<p>Continued From page 12</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date and failed to monitor for expired medications for one of one resident (R2),</p> <p>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).</p> <p>The findings include:</p> <p>R2 admitted to the licensee and began receiving assisted living services on April 11, 2023.</p> <p>R2's diagnoses included type 2 diabetes.</p> <p>R2's Service plan, dated effective as of February 7, 2025, indicated R2's services included bathing, diabetic monitoring, housekeeping, laundry, and medication administration.</p> <p>On July 28, 2025, at 10:38 a.m., the surveyor observed the contents of R2's medication cabinet and fridge, which contained one opened bottle of</p>	01890		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(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
01890	<p>Continued From page 13</p> <p>Latanoprost eye drops with an expiration date of June 17, 2025, and one opened Lantus SoloStar pen undated with open or expired date.</p> <p>On July 28, 2025, at 10:39 a.m., licensed assisted living director (LALD)-A stated "staff are to place the open and expiration date on insulin pens, but they must have forgotten to with this medication. I will take the eye drops to the nurse. Staff are to read the expiration date and take the expired medication to the nurse to dispose".</p> <p>The manufacturer's instruction for storing opened pens of Lantus indicated, store the Lantus SoloStar injection pen at room temperature (do not refrigerate) and use within 28 days.</p> <p>The licensee's procedure 3-2 Storage of Medications policy dated August 2021, indicated medications must be kept legible with expiration date of time dated drugs and stored per manufactures recommendations.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		
01910 SS=D	<p>144G.71 Subd. 22 Disposition of medications</p> <p>(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.</p> <p>(b) The facility shall dispose of any medications</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	<p>Continued From page 14</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of medications for one of one resident (R4) upon discharge.</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on July 28, 2025, at 9:38 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.</p> <p>The licensee's Discharged or Deceased Resident Roster indicated R4 was admitted to the facility</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2025</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	<p>Continued From page 15</p> <p>on May 20, 2024, and discharged on June 4, 2025.</p> <p>On July 28, 2025, at 12:41 p.m., licensed assisted living director (LALD)- A stated "Attached is the discharge summary for R4; family received meds. Medication Disposition form is not available."</p> <p>On July 29, 2025, registered nurse (RN)-B stated RN-B only performed a disposition of the narcotic medications.</p> <p>The licensee's 3-5 Disposition of Medications policy dated August 2021, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the date, medications name, strength, quantity, and nature of person destroying the drugs and signature of witness to the destruction.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01910		



St Cloud District Office  
Minnesota Department of Health  
4140 Thielman Lane, Suite 101  
St Cloud, MN 56301  
Phone: 651-201-4500

## Food & Beverage Inspection Report

Page: 1

### Establishment Info

Shepherd of Grace LLC  
11175 27th Ave SE  
Becker, MN 55308  
Sherburne County  
Parcel:  
  
Phone:

### License Info

License: HFID 24881  
  
Risk:  
License:  
Expires on:  
CFPM: MaDonna M. Abrahamson  
CFPM #: 76560; Exp: 01/04/2026

### Inspection Info

Report Number: F1046251062  
Inspection Type: Full - Single  
Date: 7/28/2025 Time: 11:00:09 AM  
Duration: minutes  
Announced Inspection:  
**Total Priority 1 Orders: 1**  
Total Priority 2 Orders: 0  
Total Priority 3 Orders: 3  
Delivery:

#### **New Order: 3-300C Protection from Contamination: equipment/utensils, consumers**

3-304.14B *Priority Level: Priority 3 CFP#: 41*

*MN Rule 4626.0285B* Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: OBSERVED WET WIPING CLOTH ON THE COUNTER NOT STORED IN A SANITIZING SOLUTION BY THE MICROWAVE. STORE WIPING CLOTHS IN SANITIZING SOLUTION WHEN NOT IN USE.

*Comply By: Complied On Site Originally Issued On: 7/28/2025*

#### **New Order: 4-500 Equipment Maintenance and Operation**

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

*MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: 1) DISHWASHER DISH SURFACE TEMP MEASURED 152.6F, 160F IS THE MINIMUM REQUIRED TEMPERATURE. REPAIR DISHWASHER.

2) GASKET ON THE WALK IN FREEZER IS BROKEN. REPAIR WALK IN FREEZER GASKET.

*Comply By: 8/11/2025 Originally Issued On: 7/28/2025*

#### **New Order: 4-600 Cleaning Equipment and Utensils**

4-602.11D5 *Priority Level: Priority 3 CFP#: 16*

*MN Rule 4626.0845D5* Clean equipment used for the storage of packaged or unpackaged food, such as a reach-in refrigerator, at a frequency which precludes accumulation of soil residues.

COMMENT: OBSERVED ICE BUILD UP IN THE WALK IN FREEZER BY THE DOOR. A NEW GASKET HAS BEEN ORDERED FOR THE FREEZER DOOR. REMOVE ICE FROM WALLS, SHELVES, AND FLOOR.

*Comply By: 8/4/2025 Originally Issued On: 7/28/2025*

#### **! New Order: 4-700 Sanitizing Equipment and Utensils**

4-703.11B *Priority Level: Priority 1 CFP#: 16*

*MN Rule 4626.0905B* Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: UTENSIL SURFACE TEMP MEASURED 152.6F, MINIMUM TEMPERATURE REQUIRED IS 160F.

MANAGEMENT IS AWARE OF ISSUE AND PARTS HAVE BEEN ORDERED TO REPAIR DISHWASHER. OTHER METHODS TO SANITIZE DISHES WERE DISCUSSED DURING INSPECTION.

*Comply By: 8/11/2025 Originally Issued On: 7/28/2025*

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

**I acknowledge receipt of the St Cloud District Office inspection report number F1046251062 from 7/28/2025**

---

Establishment Representative



---

Nicole Larrison,  
Public Health Sanitarian 1  
320-640-3534  
nicole.larrison@state.mn.us



St Cloud District Office  
Minnesota Department of Health  
4140 Thielman Lane, Suite 101  
St Cloud, MN 56301

## Temperature Observations/Recordings

Page: 1

### Establishment Info

Shepherd of Grace LLC  
Becker  
County/Group: Sherburne County

### Inspection Info

Report Number: F1046251062  
Inspection Type: Full  
Date: 7/28/2025  
Time: 11:00:09 AM

**Food Temperature: Product/Item/Unit:** LASAGNA; **Temperature Process:** Hot-Holding

**Location:** Hot-Holding Cabinet at 177 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CUT LETTUCE; **Temperature Process:** Cold-Holding

**Location:** Walk-in Cooler at 41 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CHICKEN SALAD; **Temperature Process:** Cold-Holding

**Location:** Walk-in Cooler at 39 Degrees F.

Comment:

*Violation Issued?: No*



St Cloud District Office  
Minnesota Department of Health  
4140 Thielman Lane, Suite 101  
St Cloud, MN 56301

---

---

## Sanitizer Observations/Recordings

---

Page: 1

### Establishment Info

Shepherd of Grace LLC  
Becker  
County/Group: Sherburne County

### Inspection Info

Report Number: F1046251062  
Inspection Type: Full  
Date: 7/28/2025  
Time: 11:00:09 AM

**Sanitizing Equipment:** Product: Hot Water; **Sanitizing Process:** Dish Machine

**Location:** Dishwashing Area **Equal To** 152.6 Degrees F.

Comment:

*Violation Issued?: Yes*

**Sanitizing Chemical:** Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

**Location:** Kitchen **Equal To** 400 PPM

Comment:

*Violation Issued?: No*



St Cloud District Office  
Minnesota Department of Health  
4140 Thielman Lane, Suite 101  
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	1	Date: 7/28/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00:09 AM
Score (optional)		Dur: min

Establishment: Shepherd of Grace LLC	Address: 11175 27th Ave SE	City/State: Becker, MN	Zip: 55308	Phone:
License/Permit #: HFID 24881	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

### FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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	Description
<b>Supervision</b>			
1	IN		Person in charge present, demonstrate knowledge and performs duties
2	IN		Certified Food Protection Manager
<b>Employee Health</b>			
3	IN		knowledge, responsibilities, and reporting
4	IN		Proper use of restriction and exclusion
5	IN		Response to vomiting, diarrheal events
<b>Good Hygienic Practices</b>			
6	IN		Proper eating, tasting, drinking, tobacco use
7	IN		No discharge from eyes, nose, and mouth
<b>Preventing Contamination by Hands</b>			
8	IN		Hands clean and properly washed
9	IN		No bare hand contact with RTE foods, alternatives
10	IN		Adequate handwashing sinks supplied and access
<b>Approved Source</b>			
11	IN		Food obtained from approved source
12	N/O		Food Received at proper temperature
13	IN		Food in good condition, safe & unadulterated
14	N/A		Records available: shellstock tags, parasite dest.
<b>Protection From Contamination</b>			
15	IN		Food separated and protected
16	OUT		Food-contact surfaces; cleaned & sanitized
17	IN		Proper Disposition of returned, previously served, reconditioned, & unsafe food

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

**Risk factors** are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions 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" or OUT 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

Compliance Status	COS	R	Description
<b>Safe Food and Water</b>			
30	N/A		Pasteurized eggs used where required
31			Water & ice from approved source
32	N/A		Variance obtained for specialized processing methods
<b>Food Temperature Control</b>			
33			Proper cooling methods used; adequate equipment for temperature control
34	N/O		Plant food properly cooked for hot holding
35	IN		Approved thawing methods used
36			Thermometers provided & accurate
<b>Food Identification</b>			
37			Food properly labeled; original container
<b>Prevention of Food Contamination</b>			
38			Insects, rodents, & animals not present; no unauthorized person
39			Contamination prevented during food prep, storage, & display
40			Personal cleanliness
41	X		Wiping cloths: properly used & stored
42			Washing fruits & vegetables

Compliance Status	COS	R	Description
<b>Proper Use of Utensils</b>			
43			In-use utensils; Properly stored
44			Utensils, equipment & linens; properly stored, dried, handled
45			Single-use & single-service articles, properly stored and used
46			Gloves used properly
<b>Utensils, Equipment and Vending</b>			
47	X		Food & non-food contact surfaces cleanable, properly designed, constructed, & used
48			Warewashing facilities: installed, maintained, used; test strips
49			Non-food contact surfaces clean
<b>Physical Facilities</b>			
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 and plan review

Person in Charge (signature)

Inspector (signature)

Follow-up:

Follow-up Date: