DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee
Grace Homes - Oakridge
601 Oak Ridge Road
Hopkins, MN 55305

RE: Project Number(s) SL28023015

Dear Licensee:

On August 7, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders were corrected from the February 22, 2024, survey and the May 15, 2024 follow-up survey. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

June 12, 2024

Licensee
Grace Homes - Oakridge
601 Oak Ridge Road
Hopkins, MN 55305

RE: Conditional License Number 416852
Health Facility Identification Number (HFID) 28023
Project Number(s) SL28023015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on May 15, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **September 10, 2024**.

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

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 22, 2024, found not corrected at the time of the May 15, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on May 15, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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.

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

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

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. 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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Grace Homes - Oakridge a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Grace Homes - Oakridge is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **Health Facility Construction Permit:** Grace Homes - Oakridge, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Grace Homes - Oakridge, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Grace Homes - Oakridge must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
    i. Name
    ii. License Number
    iii. Contact Information

c. **Egress Window Requirements:** Grace Homes - Oakridge will replace at least one window in occupied resident sleeping rooms #4 meeting the minimum size requirements.
    i. Must have a minimum openable width of no less than 20 inches
    ii. Must have a minimum openable height of no less than 20 inches

iii. Must have a total openable area of no less than 648 square inches (4.5 square fee).
iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Grace Homes - Oakridge is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Grace Homes - Oakridge is in substantial compliance on the follow up survey, MDH will remove the conditions from Grace Homes - Oakridge's assisted living facility license, and Grace Homes - Oakridge will correct any outstanding violations identified during the survey. If Grace Homes - Oakridge is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28023	A. BUILDING: _____ B. WING _____	R 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HOMES	601 OAK RIDGE ROAD HOPKINS, MN 55305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28023015-1 On May 15, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 22, 2024. At the time of the survey, there were 6 residents; 6 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued. An immediate correction order was identified on May 15, 2024, issued for SL28023015-1, tag identification 0820. On May 17, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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{0 480}	Continued From page 1	{0 480}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of 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.	{0 650}		

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{0 650}	Continued From page 2 This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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: No further action needed.	{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	{0 680}		

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{0 680}	Continued From page 3 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: No further action needed.	{0 700}		

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{0 820}	Continued From page 4	{0 820}		
{0 820} SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect the resident in room #4 on the main level. 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 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:	{0 820}	This immediate correction order identified on May 15, 2024, has had the immediacy lifted as of May 17, 2024, however non-compliance remained a scope and level of G.	

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{0 820}	Continued From page 5 On May 15, 2024, at 12:30 p.m., survey staff toured the facility with certified nurse (CNA)-A. The clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C was not present at the time of the survey, and the interview with CNS/LALD -C was conducted over the phone. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #4 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17.5 inches in height and 39 inches in width, with a total openable area of 682 square inches. The windows did not meet the minimum requirements for opening height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CNA-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. In the original survey conducted on February 22, 2024, the facility proposed a fire watch as a corrective measure to maintain the residents' safety until the window replacement is completed. On May 15, 2024, at 1 p.m., during the interview with CNA-A, survey staff requested the fire watch record for the facility, but she was unaware of the provision and could not provide any fire watch record.	{0 820}		

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{0 820}	Continued From page 6 During the interview on May 15, 2024, at 2:00 p.m., CNS/LALD-C stated the window had been ordered and waiting on arrival. About the fire watch record, CNS/LALD-C stated that she discussed the fire watch procedure with staff at the time of the original survey, but on-site staff not provided fire watch, and confirm there was no fire watch record in the facility. During the interview on May 15, 2024, at 3:00 p.m., survey staff explained to CNS/LALD-C that an immediate correction order was issued for the above finding. CNS/LALD-C acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	{0 820}		
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your	{0 950}		

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{0 950}	Continued From page 7 guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action needed.	{0 950}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	{01500}		

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{01500}	Continued From page 8 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}		

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{01500}	Continued From page 9	{01500}		
{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: No further action needed.	{01620}		

Electronically Delivered

March 7, 2024

Licensee
Grace Homes - Oakridge
601 Oak Ridge Road
Hopkins, MN 55305

RE: Project Number(s) SL28023015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

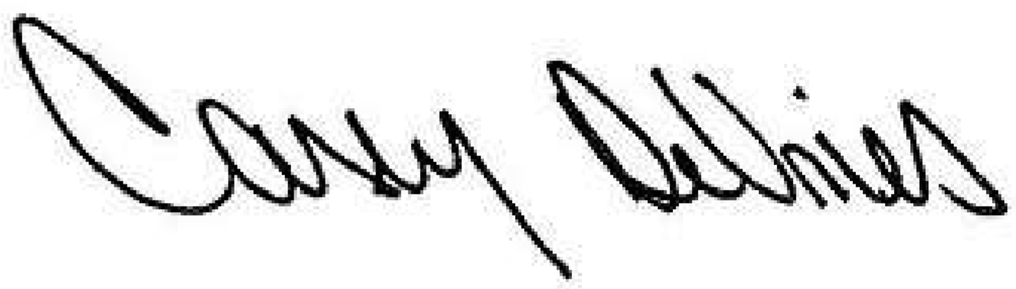
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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 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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28023	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HOMES- OAKRIDGE	601 OAK RIDGE ROAD HOPKINS, MN 55305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28023015-0 On February 20, 2024, through February 22, 2024, 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 six residents: all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on February 22, 2024, issued for SL28023015-0, tag identification 0820. On February 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 2 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two unlicensed personnel ((ULP)-B and ULP-D) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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	0 650		

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0 650	Continued From page 3 a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on November 4, 2021, to perform direct care services to the licensee's residents. ULP-D ULP-D was hired on March 27, 2023, to perform direct care services to the licensee's residents. ULP-B and ULP-D's record lacked documentation they were trained and found competent by the RN to provide medications to residents who may have an unplanned time away from home. On February 21, 2024, at 9:21 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "For meds for LOA (leave of absence) I train them buy showing them what to do in Educare (a computer software used for educational training modules) for medication administration, but I do not have anything documented, but they are all trained because [R1] goes out every weekend and they need to know how to send the meds out." On February 21, 2024, at 10:30 a.m., ULP-B stated, "We were trained by the RN on how to send meds out with a resident who was going out, we have one that we have to send meds with all the time." The Licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy, dated August 1, 2021, read, "Our facility will provide the necessary medications, education, instructions	0 650		

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0 650	Continued From page 4 and support to meet the resident's medication needs when they are away from home if the facility provides assistance with self-administration of medication, administration, administration or storage of medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medications." The Licensee's Personnel Records policy, dated August 1, 2021, directed the personnel record will include, in part, record of all required training for unlicensed personnel and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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	0 660		

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0 660	Continued From page 5 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 tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. 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: On February 20, 2024, at 10:05 a.m., during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided the surveyor with the licensee's TB risk assessment dated August 1, 2022, and stated, "Our TB risk assessment is from 2022 and we do it every other year, so it is due to be completed again this year." The Licensee's TB Prevention and Control policy dated August 1, 2021, read, "The clinical nurse supervisor is responsible for establishing and maintaining the TB prevention and control program. Responsibilities include: a. Establishment of an infection control team	0 660		

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0 660	Continued From page 6 b. Completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health. c. Annual review and revision as needed of the TB risk assessment for the facility. Based on the risk assessment, the Clinical Nurse Supervisor will determine the frequency of TB screening and testing necessary for assisted living staff." The Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019 dated May 16, 2019, indicated all health care personnel should have a baseline TB screening including an individual risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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; (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	0 680		

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0 680	Continued From page 7 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - subsistence needs for staff and residents including safe/sanitary storage of provisions; - policy or procedure to address role of facility	0 680		

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0 680	Continued From page 8 under a waiver declared by the Secretary in accordance with section 1135 of the Act; - develop a written communication plan; - communication plan must include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On February 21, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "I didn't realize that some of that was missing, so I need something listed for what the needs are for the residents? I have something that says we need adequate amounts of items but nothing explaining what would be adequate. The roles under the waiver were so confusing so I wasn't sure what to do for that, its just really confusing, and I do have a communication plan but it is located in Rtasks (a computer software used for charting), so if they don't have access to Rtasks they can't see it because I do not have anything printed out, but I can fix that." No further information was provided.	0 680		

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0 680	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R1 and R2) personal health and medical information was kept private. 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: On February 20, 2024, from 11:48 a.m. to 12:02 p.m., the surveyor observed unlicensed personnel (ULP)-B verify R2's medications and then left R2's medical information including resident's name and medications open on Rtasks	0 700		

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0 700	Continued From page 10 (an electronic medical charting software) while ULP-B proceed to move throughout the facility to pass medication and serve lunch. The surveyor observed one resident and one staff that was not responsible for medications, pass directly by the unattended laptop that was located in an open and accessible alcove off the kitchen. On February 20, 2024, from 12:20 p.m., to 12:26 p.m., the surveyor observed ULP-B verify R1's medications. ULP-B then left R1's medical information including residents name and medications open on Rtasks while ULP-B proceeded to another area of the facility to administer medications to R1. The surveyor observed one resident pass directly by the unattended laptop located in the alcove off the kitchen. On February 20, 2024, at 12:26 p.m., ULP-B stated, "I don't normally leave the screen up I usually minimize it but was in a hurry." On February 20, 2024, at 12:56 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "They (staff) are supposed to minimize that (Rtasks) or log out of it completely. They should never leave resident information open for others to access." The licensee's Confidentiality of Resident Records and Information and Access to Records policy, dated August 1, 2019, read, "Resident records and resident information will be kept confidential unless the resident or the resident's designated representative give permission for release of confidential information." No further information was provided.	0 700		

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0 700	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 22, 2024, at 9:00 a.m., survey staff toured the facility with the clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and human resources (HR)-A.	0 800		

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0 800	Continued From page 12 During the facility tour, it was observed on the wooden deck outside of the exit door to the backyard, burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. On February 22, 2024, at 9:00 a.m., CNS/LALD-C and HR-A verified there was not a fire safe disposal container for smoking residents. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential	0 820		

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0 820	Continued From page 13 to directly affect all residents. 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: On February 22, 2024, at 9:00 a.m., survey staff toured the facility with the clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and human resources (HR)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 39 inches in width, with a total openable area of 624 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #4 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17.5 inches in height and 39 inches in width, with a total openable area of 682 square inches. The windows did not meet the minimum requirements for opening height.	0 820		

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0 820	Continued From page 14 It was observed that occupied resident bedroom #5 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17.5 inches in height and 30 inches in width, with a total openable area of 525 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #7 and #8 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 11 inches in height and 43 inches in width, with a total openable area of 473 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that unoccupied resident bedroom #3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18 inches in height and 39 inches in width, with a total openable area of 702 square inches. The windows did not meet the minimum requirements for opening height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CNS/LALD-C and HR-A that at least one egress window in each bedroom must be provided to meet the minimum state standard	0 820		

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0 820	Continued From page 15 for an egress window to be a complying bedroom for resident occupancy. CNS/LALD-C and HR-A verbally confirmed the findings. On February 22, 2024, at 10:00 a.m., during the interview, survey staff explained to CNS/LALD-C and HR-A that an immediate correction order was issued for the above finding. CNS/LALD-C and HR-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On February 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950		

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0 950	Continued From page 16 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for all 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 the residents). The findings include: On February 20, 2024, at 10:05 a.m., during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided the surveyor with the licensee's blank contract and indicated it was the contract used for all residents. The contract had a spot to identify the resident's designated representative on the signature page of the	0 950		

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0 950	Continued From page 17 contract, but lacked the required statutory language for the designated representative located on a seperate document from the contract. On February 20, 2024, at 10:52 a.m., CNS/LALD-C stated, "That contract (blank contract) is the same for every resident, there is a spot for the designated representative towards the end of the contract. I didn't know it needed certain wording though, so I will need to get that fixed for everyone, I can do that." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 18 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01500		

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01500	Continued From page 19 licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-B) 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 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: ULP-B was hired on November 4, 2021, to perform direct care services to the licensee's residents. ULP-B's record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Infection control techniques; - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery. On February 21, 2024, at 9:21 a.m., clinical nurse supervisor/licensed assisted living director	01500		

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01500	Continued From page 20 (CNS/LALD)-C stated, "For [ULP-B] I don't think she has all of her annual education so I will have to get those courses added into Educare (online training program) for her to get it taken care of. Everyone will be missing that training because it was overlooked and they need to get the Educare courses assigned to get everyone caught up." The licensee Assisted Living Annual Training policy, dated August 1, 2021, read, "1. All assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557 b. Assisted living bill or rights c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights d. Infection control techniques used in the home and implementation of infection control standards including i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery	01500		

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01500	Continued From page 21 i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training 2. Annual training will be documented in accordance with the documentation policy. 3. Direct-care staff will complete 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01620		

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01620	Continued From page 22 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 nursing assessments not to exceed every 90-days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: On February 20, 2024, at 10:05 a.m., during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated ongoing assessments were completed every 90 days and with change of condition. R1 began receiving assisted living services from the licensee on October 2, 2020. R1's diagnoses included traumatic brain injury and diabetes. R1's Signed Service Plan dated March 6, 2023, indicated R1 required assistance with medication administration, ambulation, dressing/grooming	01620		

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01620	Continued From page 23 AM and PM cares, showering, safety checks, blood glucose monitoring, and vitals. R1's record included nursing assessments dated May 3, 2023, August 15, 2023, and January 20, 2024. The assessments completed indicated 104 and 159 days, respectively, had passed between assessments. On February 20, 2024, at 1:53 p.m., CNS/LALD-C brought the surveyor resident records and stated, "Assessments are late and I acknowledge that, I just wanted to tell you before you find it." The surveyor asked if they had identified the reason assessments were late and CNS/LALD-C stated, "There is a reminder on the Rtask dashboard (an electronic charting software) to remind me that the 90 days are due but life happened, and I got behind on everyone, so if you look at [R1 or R2] you will see the same, I am behind in all of them by a couple months, but I am getting them all back on track." The licensee's Initial and On-Going Nursing Assessment of Residents policy, dated August 1, 2021, read, "1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *02/20/24*
Time: 14:00:00
Report: 8041241027

Food and Beverage Establishment Inspection Report

Location:
Grace Homes- Oakridge
601 Oak Ridge Road
Hopkins, MN55305
Hennepin County, 27

Establishment Info:
ID #: 0038160
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523034305
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

CARTONS OF UNPASTEURIZED SHELL EGGS STORED ABOVE READY-TO-EAT FOODS IN THE REFRIGERATOR. DISCUSSED PROPER STORAGE ORDER TO PREVENT CROSS CONTAMINATION. EGGS WILL BE MOVED TO A BOTTOM DRAWER.

Comply By: 02/20/24

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.

BUTTER STORED ON THE COUNTER FROM TWO DAYS AGO AT 76F. DISCARDED. BUTTER IS A TCS FOOD AND MUST BE STORED USING MECHANICAL REFRIGERATION.

Comply By: 02/20/24

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. STAFF TOOK A FOOD SAFETY CLASS MORE THAN 6 MONTHS AGO AND WILL NEED TO RETAKE INITIAL CLASS THEN SUBMIT CFPM APPLICATION TO MDH.

Comply By: 04/20/24

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: kitchen spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: samsung cooler: sour cream
Violation Issued: No

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

Inspection was completed with the Food Service Manager, Addison Thao. Tesa Brown was the lead Health Regulation Division Nurse Evaluator. Facility had six residents on site at time of inspection. Meals are prepared on site. Staff also prepare some food items at the neighboring facility (Grace Homes- Wilshire Walk).

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has cabinetry on stainless six inch legs, a solid surface countertop and epoxy flooring. All found to be in good condition.

Establishment has a two basin sink and a separate handwashing sink. The Bosch dish machine was recently tested using thermal strip and had a utensil surface temperature of at least 160F.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Chlorine sanitizer concentration
-Monitoring food temperatures and protecting food from contamination
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 8041241027 of 02/20/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Addison Thao

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
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