Electronically Delivered

October 16, 2024

Licensee
Grace Hand Group Home LLC
2738 Oakland Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL37639015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 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.

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 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $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. 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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37639	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HAND GROUP HOME LLC	2738 OAKLAND AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 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: SL37639015-0 On September 16, 2024, through September 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during medication administration by one of one employee (unlicensed personnel (ULP)-D). 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 September 16, 2024, at 12:43 p.m., the surveyor observed ULP-D perform hand hygiene, apply gloves, remove R1's medication from the medication cabinet and log onto the computer to	0 510		

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0 510	Continued From page 2 verify R1's medication orders. ULP-D then brought R1's medications to his room. R1 stated he was in the bathroom and requested ULP-D return later with his medication. ULP-D placed R1's medication back in the medication cabinet to administer later. ULP-D then removed her gloves and did not perform hand hygiene. -at 1:07 p.m., ULP-D put gloves on, removed R1's medication from the medication cabinet and administered it to R1. ULP-D then documented the administration on the computer and removed her gloves. ULP-D did not perform hand hygiene after her gloves were removed. On September 17, 2024, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to perform hand hygiene prior to applying gloves and again after gloves were removed. CNS-B further stated the ULP should have changed gloves between performing different tasks. The licensee's Hand Washing policy dated July 16, 2021, indicated handwashing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 3 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On September 16, 2024, at 9:30 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting	0 640		

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0 640	Continued From page 4 of the information and reporting number for MAARC, as required. Licensed assisted living director (LALD)-A stated the MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	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: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees	0 660		

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0 660	Continued From page 5 (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on May 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record contained a clinical document dated February 22, 2024, that indicated ULP-E had a "positive QuantiFERON gold test; no cardiac enlargement, pulmonary vasculature is normal, lungs are clear, no pleural effusion, no skeletal abnormality". The clinical document also indicated ULP-E had a negative chest x-ray indicating no evidence of active tuberculosis. However, ULP-E's employee record lacked evidence of a TB history and symptom screening. On September 17, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated ULP-E's employee record did not include a TB history and symptom screening. The licensee's Tuberculosis Screening policy dated July 16, 2021, indicated employees would receive a baseline TB screening upon hire to test for infection with M. tuberculosis. No further information was provided.	0 660		

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0 660	Continued From page 6 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 (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 observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include	0 680		

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0 680	Continued From page 7 Appendix Z required elements and failed to post the plan prominently. 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 the residents). The findings include: The licensee's Emergency Preparedness plan dated June 10, 2024, was reviewed and lacked the following: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans); - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate	0 680		

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0 680	Continued From page 8 sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP;	0 680		

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0 680	Continued From page 9 - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation 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 community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On September 17, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated the EP plan did not include the required content as listed above. The licensee's Emergency Preparedness Plan-Appendix Z policy dated July 16, 2021, indicated the licensee's emergency plan would include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=A	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 10 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a working smoke alarm in the living room area of the home. This has the potential to directly affect the health, safety, and well-being of the resident(s) and/or staff.. 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 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: On September 17, 2024, from approximately 10:15 a.m. to 11:15 a.m., survey staff toured the	0 780		

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0 780	Continued From page 11 home with licensed assisted living director (LALD)-A. During the tour, survey staff observed there were multiple smoke alarms were installed on the main level floor. When the smoke alarm in the main-level living room area was tested by LALD-A, it failed to operate and sound. LALD-A stated that the wire must be loose. The above finding was verified by LALD-A at the time of discovery. On September 17, 2024, at approximately 11:45 a.m., LALD-A acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff.	0 800		

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	37639	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HAND GROUP HOME LLC	2738 OAKLAND AVENUE SOUTH MINNEAPOLIS, MN 55407

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0 800	Continued From page 12 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 September 17, 2024, from approximately 10:15 a.m. to 11:15 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the home tour, survey staff observed the following: -The upper-level resident sleeping room egress windows were not maintained for easy and ready operation for immediate use as LALD-A had difficulty opening the egress windows during the tours of the rooms. Survey staff explained to LALD-A that egress sleeping windows must be easily operable and openable for immediate use at all times. -Insufficient lighting in the basement near the stairway for safe egress and near the electrical breaker panel for proper use during an emergency. -Substantial standing/ponding of water in a corner floor of the basement near the electrical panel. Further investigation indicated a condensate pipe was discharging onto the floor without a drain. LALD-A confirmed the finding and agreed to correct the deficient conditions. -The furnace filter was filled with thick dust and dirt. LALD-A concurred and took a picture to send to their maintenance person. -No approved cigarette butt receptors were	0 800		

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0 800	Continued From page 13 provided for proper disposal in the home's designated smoking area in the back and front of the house. LALD-A stated that he thought he had a receptacle in the back but could not locate it. -Failed to maintain the kitchen exit door to allow residents, staff, and visitors to exit the building (as shown on the posted evacuation diagram) in a safe and efficient manner in the event of an emergency. The outdoor fence gate was secured using a knotted rope on the inside which would delay egress. -The exhaust fan cover in the main-level bathroom shower was covered with thick dust. -Unsafe height of top guardrail for the upper level floor hallway near the stairs serving upper-level resident rooms.The top guardrail on the hallway of the upper level floor was measured at 27 inches above finished floor. -The roof gutter and downspouts were disconnected in the back of the home. The above deficient findings were verbally and visually verified by LALD-A at the time of discovery. On September 17, 2024, at approximately 11:45 a.m. during the exit interview, survey staff explained the above deficient findings to LALD-A. LALD-A understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 14 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills for	0 810		

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0 810	Continued From page 15 calendar year 2023, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, from approximately 10:15 a.m. to 11:15 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -The upper-level resident bedrooms 2 and 4 were not labeled as shown on the posted fire evacuation diagram (plan). -The main-level posted evacuation plan did not include the numbering of resident bedroom 1 as labeled on the bedroom door. -A discrepancy in the posted fire evacuation plans for the main-level and upper-level floors. The main level had a bedroom door labeled 1 and the upper level posted evacuation diagram showed another room numbering of 1. LALD-A confirmed the discrepancy and stated that they were renumbering the rooms and the posted diagram had not been updated. -Incorrect signage indicating not to exit on the kitchen door to the deck designated as an approved exit door on the posted evacuation	0 810		

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0 810	Continued From page 16 diagram. LALD-A confirmed the finding at the time of discovery as LALD-A stated that they would remove the signage on the door and review their evacuation floor plan for accuracy. The above deficient findings were visually verified by LALD-A at the time of discovery. On September 17, 2024, at approximately 11:15 a.m. document and record review and interview with LALD-A, on the home's fire safety and evacuation plan, and related training policies, procedures, and records indicated the following: -The review of available documentation indicated the fire safety was incomplete in content. The plan lacked fire emergency contacts and procedures for site-specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and conditions, including for employees to call 911 if a fire is discovered. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training. During an interview, LALD-A confirmed they used third-party online training and only had conducted drills as part of training. Furthermore, the home's training and drill policy indicated training provided to employees once a year and not twice per year as required. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. LALD-A was unable to provide documentation showing any training	0 810		

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0 810	Continued From page 17 offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. Record review indicated that employee evacuation drills were conducted properly to date for the year 2024, but lacked evacuation drills for calendar 2023 as records showed one drill was conducted. During the interview, survey staff explained to LALD-A their training and drill policy incorrectly documented that drills are to be performed twice a year and needed to be revised to reflect state-required frequencies for assisted living facilities. The above deficient findings were verified by LALD-A during an interview. LALD-A understood and acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect 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: The licensee's Assisted Living Contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 14 of the agreement indicated: "Indemnification: The licensee shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold the licensee harmless from any claims or damages unless caused solely by negligence of the licensee. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident". - "Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and	0 970		

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0 970	Continued From page 19 where this contract has been executed by a party designated below. Or where a separate Responsible party agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced". On September 17, 2024, at 10:03 a.m., licensed assisted living director (LALD)-A stated the licensee's contract included the above content, and further stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370		

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01370	Continued From page 20 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01370		

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01370	Continued From page 21 The findings include: ULP-E was hired on May 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of training for: -understanding appropriate boundaries between staff and residents and the resident's family On September 17, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated ULP-E's record lacked evidence of the training listed above. The licensee's Competency Training Evaluations policy dated July 16, 2021, indicated the ULP would be trained on understanding appropriate boundaries between staff and residents and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 22 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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,	01470		

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01470	Continued From page 23 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 licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally The findings include: ULP-E was hired on May 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record did not include the following required orientation content: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 17, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated ULP-E's record lacked evidence of the training listed above. The licensee's Orientation of Staff and Supervisors and Content policy dated July 16,	01470		

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01470	Continued From page 24 2021, indicated employees would complete the orientation to assisted living facility requirements before providing assisted living services to residents which included training on: -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01620 SS=D	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	01620		

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01620	Continued From page 25 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 14 days from admission 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on January 17, 2024, with diagnoses that included altered mental status and epilepsy (seizure disorder). R1's service plan dated January 17, 2024, indicated R1 received assistance with grooming, dressing, bathing, behavior management, meal assistance, safety checks and medication administration. R1's ongoing nursing assessments were requested. Assessments dated February 3, 2024, March 23, 2024, May 4, 2024, August 2, 2024, were provided. The February 3, 2024, assessment was done 17 days after the date of admission, thus exceeding 14 calendar days.	01620		

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	37639	A. BUILDING: _____ B. WING _____	09/17/2024

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01620	Continued From page 26 On September 17, 2024, at 11:41 a.m., clinical nurse supervisor (CNS)-B stated R1's February 3, 2024, assessment exceeded 14 calendar days from the date of R1's admission. The licensee's Assessments, Reviews and Monitoring policy dated July 16, 2021, indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 27 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content 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) 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: R1 was admitted on January 1, 2024, with diagnoses that included altered mental status and epilepsy (seizure disorder). R1's service plan dated January 17, 2024, indicated R1 received assistance with grooming, dressing, bathing, behavior management, meal assistance, safety checks and medication administration. R1's service plan lacked the following content: - the fees for services; - the names and contact information of persons	01650		

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01650	Continued From page 28 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in an emergency On September 17, 2024, at 11:20 a.m., licensed assisted living director (LALD)-A stated R1's service plan did not include the required content as listed above. LALD-A stated the fees for services were not listed on any of the residents' service plans. The licensee's Service Plan policy dated July 16, 2021, indicated the service plan would include: -fees for services to be provided -a contingency plan that includes: -action to be taken if the scheduled service cannot be provided -information and method for a resident or resident's representative to contact the facility -Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition. -the identification of and information as to who has the authority to sign for the resident in an emergency -circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01730	Continued From page 29	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 30 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on January 1, 2024, with diagnoses that included altered mental status and epilepsy (seizure disorder). On September 16, 2024, the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated January 17, 2024, indicated R1 received assistance with grooming, dressing, bathing, behavior management, meal assistance, safety checks and medication administration. R1's signed prescriber orders dated May 26, 2024, included:	01730		

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01730	Continued From page 31 -alendronate sodium 70 milligrams (mg); take one tablet by mouth once a week -biktarvy 55-200-25 mg; take one tablet by mouth daily -calcium chew 500 mg; chew and swallow two tablets by mouth daily -evotazf/c 300-150 mg; take one tablet by mouth every 12 hours -famotidine 20 mg; take one tablet by mouth daily -fenofibrate 48 mg; take one tablet by mouth daily -levetiracetam 1,000 mg; take one tablet by mouth twice a day -loratadine 10 mg; take one tablet by mouth daily -mirtazapine 15 mg; take one tablet by mouth at bedtime -vitamin D 1,000 mg; take one tablet by mouth daily -acetaminophen 325 mg; take one to two tablets by mouth every six hours as needed for a headache -hydrocortisone 2.5%; apply a small amount to rectal area twice daily as needed after each bowel movement -miralax 17 grams; mix 17 grams with one cup of water and drink every day as needed for constipation -Nicotine 4 mg; chew one piece of gum every one hour as needed for nicotine cravings -ondansetron 4 mg; take one tablet by mouth every six hours as needed for nausea/vomiting R1's individualized medication management plan dated August 2, 2024, lacked the following required content: -identification of medication management tasks that may be delegated to unlicensed personnel On September 17, 2024, at 11:24 a.m., clinical nurse supervisor (CNS)-B stated R1's individualized medication management plans did	01730		

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01730	Continued From page 32 not include the required content as listed above. The licensee's Medication Management Individualized Plan policy dated July 16, 2021, indicated each individualized medication management plan would include the following: -identification of medication management tasks that may be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of one resident (R1) whose medication administration was delegated to unlicensed personnel.	01750		

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01750	Continued From page 33 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on January 17, 2024, with diagnoses that included altered mental status and epilepsy (seizure disorder). On September 16, 2024, the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated January 17, 2024, indicated R1 received assistance with grooming, dressing, bathing, behavior management, meal assistance, safety checks and medication administration. R1's signed prescriber orders dated May 26, 2024, included: -acetaminophen 325 mg (milligrams); take 1-2 tablets by mouth every six hours as needed (PRN) for headache. The licensee failed to have resident-specific instructions regarding when one tablet or two tablets of Tylenol would be given. On September 17, 2024, at 11:44 a.m., clinical nurse supervisor (CNS)-B stated there were no specific instructions regarding the dose for R1's PRN acetaminophen order.	01750		

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01750	Continued From page 34 The licensee's Medication and Treatment Orders policy dated July 16, 2024, indicated an order for medication or treatment would contain the name of the resident, a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written	01790		

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01790	Continued From page 35 procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for	01790		

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01790	Continued From page 36 one of two unlicensed personnel (ULP)-E) providing medications to residents for unplanned time away from home when the 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on May 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On September 17, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated all ULP were trained, and competency tested on providing medications to residents for unplanned time away but could not locate ULP-E's documentation of the training or competency. The licensee's Medication Management-Planned and Unplanned Time Away policy dated July 16, 2021, indicated the nurse would train the unlicensed staff and determine the unlicensed staff was competent to follow the procedures for giving medications to residents. No further information provided.	01790		

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01790	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at approximately 10:00 a.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor was shown a file cabinet in the employee office where all residents' medications were stored. The surveyor noted a set of keys sitting on top of the file cabinet that stored the medications. CNS-B opened the unlocked file cabinet to show the surveyor the medications, and then locked the	01880		

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01880	Continued From page 38 medication cabinet using the keys that were on the top of the medication cabinet. On September 16, 2024, at 12:37 p.m., the surveyor observed unlicensed personnel (ULP)-D remove R2's medications from the locked mediation cabinet to prepare for administration. ULP-D brought R2's medications to his room. The keys to the medication cabinet were left in the lock. The medication cabinet was left unsecured and unattended for approximately five minutes. On September 17, 2024, at 8:28 a.m., the surveyor observed ULP-D remove R1's medications from the locked medication cabinet to prepare medications for administration. ULP-D brought R1's medications to him in the living room. The keys to the medication cabinet were left in the lock. The medication cabinet was left unsecured and unattended for approximately ten minutes. On September 17, 2024, at 11:21 a.m., CNS-B stated the medication cabinet should be locked when not in use and expected the staff to carry the keys with them. The licensee's Medication Storage policy dated July 16, 2021, indicated medications would be kept securely locked and stored per manufacturer's direction. It further indicated only authorized staff would have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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03090	Continued From page 39	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not 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 finding include: On September 16, 2024, at approximately 9:30 a.m. upon arriving at the establishment, the surveyor observed the incorrect electronic monitoring notice posted on at the entrance to the licensee's facility, which read: "24 hour video surveillance."	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37639	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HAND GROUP HOME LLC	2738 OAKLAND AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
03090	Continued From page 40 On September 17, 2024, at 10:00 a.m., licensed assisted living director (LALD)-A stated the sign was posted at the front door did not include the following statement "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *09/17/24*
Time: 15:18:18
Report: 1018241154

Food and Beverage Establishment Inspection Report

Location:
Grace Hand Group Home Llc
2738 Oakland Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0038673
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122037301
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK WITH ONE SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED ILLNESS LOG.

Type: Full
Date: *09/17/24*
Time: 15:18:18
Report: 1018241154
Grace Hand Group Home Llc

Food and Beverage Establishment Inspection Report

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

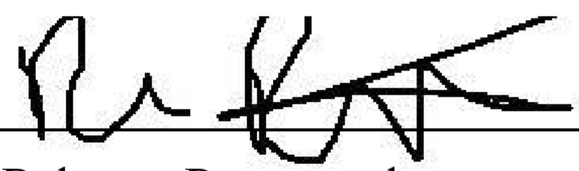
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241154 of 09/17/24.

Certified Food Protection Manager: HUSSEIN HUSSEIN

Certification Number: 121881 Expires: 11/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
HASSAN HAYDAR
MANAGER

Signed: 
Rebecca Prestwood
Sanitarian 3
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rebecca.prestwood@state.mn.us