



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2025

Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

RE: CCN: 24E150
Cycle Start Date: January 21, 2025

Dear Administrator:

On January 21, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 21, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

Grand Avenue Rest Home

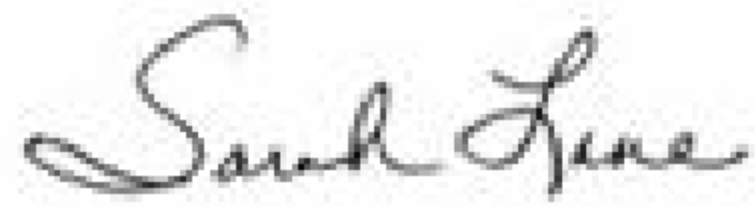
February 4, 2025

Page 4

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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Electronically delivered
February 4, 2025

Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

Re: State Nursing Home Licensing Orders
Event ID: OI6Z11

Dear Administrator:

The above facility was surveyed on January 16, 2025 through January 21, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

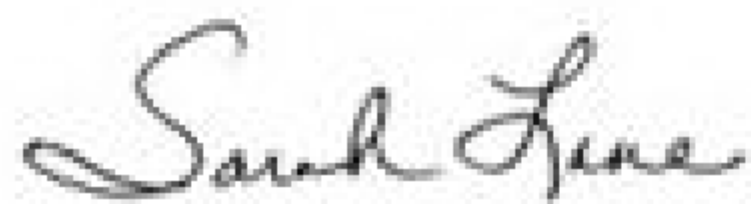
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2025
NAME OF PROVIDER OR SUPPLIER GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/16/25 and 1/21/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. HE1504501C (MN00103940) and HE1505380C (MN00101633). The following complaints were reviewed. HE1505180C (MN00109831) with a deficiency issued at F657 and F727. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657			2/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prepare resident care plans with an interdisciplinary team (IDT) to include a nursing aide (NA), the attending physician, or a resident/resident representative. This deficiency had the ability to affect all 19 residents. Findings include: During an interview on 1/21/25 at 9:11 a.m., the director of nursing (DON) stated the IDT consists of an RN, the administrator, herself, the social worker, a member from medical records, the infection preventionist (IP) nurse, the minimum data set (MDS) nurse, and a compliance nurse. During an interview on 1/21/25 at 9:39 a.m., the administrator stated the facility's IDT consists of a	F 657	All residents have the potential to be affected by this defiant practice. Immediate actions taken to prepare resident care plans with an interdisciplinary team (IDT) to include a nursing aide (NA) with responsibility for the resident, the attending physician, a resident/resident representative, registered nurse with responsibility for the resident and a member of food and nutrition services staff. An audit of all residents will be conducted by The Social Service Director or designee to make sure all resident care plans are prepared with an interdisciplinary team (IDT) to include nursing aide (NA) with responsibility for		

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F 657	Continued From page 2 RN, the DON, a member of the activities department, herself, the social services director, the social services assistant, and a member of the kitchen. During an interview on 1/21/25 at 11:35 a.m., the DON stated they do not take IDT notes. The DON stated during the IDT meetings they will look at the risk management and then they will update the care plan. The DON stated they do not take notes as to what they talk about or who attends the meetings. The facility's "IDT" policy revised on 12/24 stated the IDT will consist of the DON, one other nurse designated by the DON, social services director and/or the social services assistant, the activity director and/or designee, and other staff members as established by the Administrator.	F 657	the resident, the attending physician, a resident/resident representative, registered nurse with responsibility for the resident and a member of food and nutrition services staff. All staff received refresher training that all resident care plans are prepared with an interdisciplinary team (IDT) a nursing aide (NA) with responsibility for the resident, the attending physician, a resident/resident representative, registered nurse with responsibility for the resident and a member of food and nutrition services staff.The MDS Coordinator and Social Service Director were also educated on how to send out invitations and document care plan meetings. Every week, all residents who had their care plan reviewed during the previous seven days will be audited to ensure that all resident care plans were prepared with an interdisciplinary team (IDT) to include a nursing aide (NA) with responsibility for the resident, the attending physician, a resident/resident representative, registered nurse with responsibility for the resident and a member of food and nutrition services staff.The Social Service Director or designee will oversee supervising these audits. The outcomes of these audits will be discussed once a month at the weekly IDT meeting for a period of six months, or until three consecutive months of compliance of 90% or above is attained.		

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F 657	Continued From page 3	F 657	The IDT¿Committee will look for any trends or patterns and offer suggestions to update the correction plan as necessary. ¿ Audits will be brought to QAPI to determine future noncompliance.¿ The director of nursing overseas reporting to QAPI, auditing information, and maintaining compliance.¿		2/21/25
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure their director of nursing (DON) was a registered nurse (RN) when the facility had a licensed practical nurse (LPN) in the DON role since 7/30/24. This deficiency had the ability the affect all 19 residents. Findings include:	F 727			

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F 727	Continued From page 4 During an interview on 1/16/25 at 11:39 a.m., the administrator stated the DON is a LPN. The administrator she knew the facility has to hire an RN to be in the DON role. There is not a signed DON job description for the current DON. During an email correspondence on 1/16/25 at 2:21 p.m., the administrator stated the DON has been in her role since 7/30/24. During an interview on 1/21/25 at 9:11 a.m., the DON stated she is a LPN who worked a the facility full time. On 1/16/25, the facility provided the DON's LPN license which is valid. The facility provided the DON's education which did not contain any training for the DON role. The facility provided an undated "Director of Nursing" job description. The description stated an RN must be hired in the DON role.	F 727	affected by this deficient practice. The facility will ensure that a registered nurse is designated to serve as the DON on a full-time basis. The Administrator will ensure that the facility has registered nurse coverage for at least eight consecutive hours/ seven days per week.¿ The facility administrator has been educated that a registered nurse is designated to serve as the DON on a full-time basis. All staff are made aware of the new DON. The Administrator revised policies and procedures that state the DON job description must be filled by an RN, and all future job descriptions will comply with state regulations. The administrator will only appoint an RN as a DON in the future.¿¿ Audits will be completed weekly by the administrator or designee to ensure that a registered nurse is designated to serve as the DON on a full-time basis and there is registered nurse coverage Daily for eight consecutive hours, seven days per week. Audits will be brought to QAPI by the administrator to determine future noncompliance.¿ The administrator will oversee reporting to QAPI, auditing information, and maintaining compliance.¿		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2025
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/16/25 and 1/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/07/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2025
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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. HE1504501C (MN00103940) and HE1505380C (MN00101633). The following complaints were reviewed. HE1505180C (MN00109831) with a licensing order issued at 0720. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000			
2 720	MN Rule 4658.0500 Subp. 2 Director of Nursing Services; full time Subp. 2. Requirement of full-time employment. A director of nursing services must be employed full time, no less than 35 hours per week, and be assigned full time to the nursing services of the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure their director of nursing (DON) was a registered nurse (RN) when the facility had a licensed practical nurse (LPN) in the DON role since 7/30/24. This deficiency had the ability the affect all 19 residents. Findings include: During an interview on 1/16/25 at 11:39 a.m., the administrator stated the DON is a LPN. The administrator she knew the facility has to hire an RN to be in the DON role. There is not a signed DON job description for the current DON.	2 720	This discovery has not had an adverse effect on any residents. To correct this deficiency, the facility immediately hired a qualified RN for the Director of Nursing (DON) role.¿ All residents have the potential to be affected by this deficient practice.¿ A DON has been appointed to oversee nursing services.¿All staff are made aware of the new DON.¿¿ The Administrator revised policies and procedures that state the DON job		2/21/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2025
NAME OF PROVIDER OR SUPPLIER GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(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	
2 720	Continued From page 3 During an email correspondence on 1/16/25 at 2:21 p.m., the administrator stated the DON has been in her role since 7/30/24. During an interview on 1/21/25 at 9:11 a.m., the DON stated she is a LPN who worked a the facility full time. On 1/16/25, the facility provided the DON's LPN license which is valid. The facility provided the DON's education which did not contain any training for the DON role. The facility provided an undated "Director of Nursing" job description. The description stated an RN must be hired in the DON role. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 720	description must be filled by an RN, and all future job descriptions will comply with state regulations. The administrator will only appoint an RN as a DON in the future.¿¿ ¿All staff were educated in the revisions of the job description and policies and procedures.¿ The administrator will monitor the DON qualifications quarterly to ensure ongoing compliance. Audits will be brought to QAPI to determine future noncompliance by the administrator.¿ ¿		