



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 8, 2025

Licensee
Grace Group Home LLC
3538 Fremont Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL35191015

Dear Licensee:

On December 3, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 11, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 16, 2024

Licensee
Grace Group Home LLC
3538 Fremont Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL35191015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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:

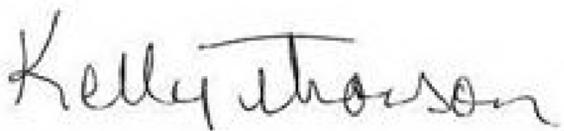
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2024
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NAME OF PROVIDER OR SUPPLIER GRACE GROUP HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55412
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL35191015-0</p> <p>On September 9, 2024, through September 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 110	<p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On September 9, 2024, at 11:00 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living director (LALD) held a current assisted living director license, however, was not listed as the director of record for the licensee.</p> <p>On September 9, 2024, at 11:00 a.m., housing manager (HM)-A acknowledged the BELTSS website did not have their LALD listed as the director of record. HM-A provided a screen shot from the BELTSS website showing the LALD was previously listed as director of record in March</p>	0 110		

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0 110	<p>Continued From page 2</p> <p>2024. HM-A stated she would try and call him to find out why he was no longer listed.</p> <p>On September 10, 2024, at 2:10 p.m., housing manager (HM)-A stated LALD was out of the country and so she was unable to get in touch with him to see why the website was no longer showing him as the director of record.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 110		
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and</p>	0 480		

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0 480	Continued From page 3 Beverage Establishment Inspection Report (FBEIR) dated September 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 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 observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of two employees unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a	0 660		

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0 660	<p>Continued From page 4</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>The facility TB risk assessment indicated the facility was at a low risk for TB transmission.</p> <p>ULP-B was hired April 22, 2022, to provide direct care services for residents.</p> <p>On September 11, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications to R2.</p> <p>ULP-B's employee record included a negative QuantiFERON TB Gold blood test dated December 1, 2021, greater than 90 days prior to the April 22, 2022, hire date.</p> <p>On September 10, 2024, at 2:10 p.m., housing manager (HM)-A stated she did not realize the TB blood test for ULP-B was not acceptable and was not aware of the 90 days prior to hire requirement and would have ULP-B retest.</p> <p>The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices</p>	0 660		

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0 660	<p>Continued From page 5</p> <p>in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components:</p> <ol style="list-style-type: none"> 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and <p>An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., frst step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients."</p> <p>The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated, "[Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH).</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:</p> <ol style="list-style-type: none"> (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 	0 680		

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0 680	<p>Continued From page 6</p> <p>elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(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.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z that was posted prominently to access in case of an emergency. This had the potential to effect all residents, employees, and visitors to the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p>	0 680		

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0 680	<p>Continued From page 7</p> <p>The findings include:</p> <p>On September 9, 2024, at 2:00 p.m., housing manager (HM)-A stated the EPP was stored in the locked office downstairs.</p> <p>The licensee's emergency preparedness plan (EPP), dated January 22, 2022, lacked the required content:</p> <ul style="list-style-type: none"> - annual review; - missing resident quarterly review; - development of EPP policies and procedures; <ul style="list-style-type: none"> - policies and procedures for volunteers; and - roles under a waiver declared by secretary. <p>On September 9, 2024, at 3:10 p.m., HM-A stated the EPP was missing some of the required pieces and they did not have documentation of the EPP being updated annually or the missing person policy reviewed quarterly.</p> <p>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The Emergency Disaster Plan is prominently posted on each floor of the facility. The emergency preparedness plan/program will be reviewed/updated at least annually.</p> <p>The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director</p>	0 680		

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0 680	Continued From page 8 and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	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 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	0 780		

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0 780	<p>Continued From page 9</p> <p>by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On September 10, 2024, at 10:30 a.m., survey staff toured the facility with the housing manager (HM)A. During the facility tour, it was observed the sleeping rooms on the lower level that were equipped with smoke alarms were not interconnected upon testing, so the actuation of one alarm would cause all alarms to operate.</p> <p>During the interview on September 10, 2024, at 11:00 a.m., HM-A stated the smoke alarms on the lower level were not interconnected and the actuation of one alarm would not cause all alarms to operate.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	<p>Continued From page 10</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On September 10, 2024, at 10:30 a.m., survey staff toured the facility with the housing manager (HM)A. During the facility tour, survey staff observed the following items:</p> <p>Outside of the exit door to the backyard on the main level, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard.</p>	0 800		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2024
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NAME OF PROVIDER OR SUPPLIER GRACE GROUP HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55412
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	<p>Continued From page 11</p> <p>In the hallway outside bedrooms 1 and 2, it was observed that the ceiling-mounted light was missing the fixture cover.</p> <p>In the bedroom 5 and 6 in the basement, it was observed that the egress window was obstructed by a plastic well cover that was installed lower than the window head, and the well cover obstructed the egress window from opening fully .</p> <p>In bedroom 4 on the second floor, it was observed that the egress window did not stay up when HM-A tried to open the window and measure the opening size. With the current window maintenance condition, the licensee failed to provide the resident bedroom with the minimum window opening meeting the minimum state standard for egress.</p> <p>During the facility tour, HM-A visually verified these deficient findings at the time of discovery.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (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, 	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 12</p> <p>evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for 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.</p> <p>This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 13</p> <p>failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On September 10, 2024, at 11:30 a.m., housing manager (HM)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The fire safety and evacuation plan included the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system.</p> <p>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.</p> <p>During the interview on September 10, 2024, at 12:00 p.m., HM-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. HM-A also confirmed that the facility had not developed the necessary fire protection procedures for</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 14</p> <p>residents.</p> <p>TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire.</p> <p>During the interview on September 10, 2024, at 12:00 p.m., HM-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. HM-A confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.</p> <p>DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 1/15/24 at 2 p.m., 4/2/24 at 8 a.m., 7/12/24 at 11 a.m., 7/15/24 at 4 p.m., and 8/15/24 at 1 a.m., with no further drills being documented.</p> <p>During the interview on September 10, 2024, at 12:00 p.m., HM-A confirmed that the licensee did not conduct evacuation drills every other month and confirmed that the facility did not conduct two drills for the afternoon and night shifts. HM-A verified that there were no further documented drills for the facility for the year.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		

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0 830	Continued From page 15	0 830		
0 830 SS=F	<p>144G.45 Subd. 3 Local laws apply</p> <p>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.</p> <p>This MN Requirement is not met as evidenced by: Assisted living facilities must comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety and building requirements. Based on observation, interview, and record review, the licensee failed to submit the renovation project to MDH Engineering for review and approval.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On September 10, 2024, at 10:30 a.m., survey staff toured the facility with the housing manager (HM)A. During the facility tour, survey staff observed the following items:</p> <p>It was observed that the facility layout did not match the posted evacuation plan. During the same tour, it was observed that the facility added two bedrooms, one bathroom, and a living room to the existing non-finished basement, and the</p>	0 830		

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0 830	<p>Continued From page 16</p> <p>construction scope included updates of HVAC and plumbing.</p> <p>During the tour, housing manager (HM)A stated the facility completed a basement remodeling project late last year and that the facility received the permit from the city of Minneapolis. During the same interview, survey staff requested a record that proper permits were obtained and that they received a Certificate of Occupancy from the City.</p> <p>During the interview on September 10, 2024, at 12:30 p.m., owner(O)-D provided a permit application and a plumbing permit from the city of Minneapolis but was not able to provide any inspection record or a Certificate of Occupancy from the City.</p> <p>During the same interview, survey staff explained to O-D that renovation or physical changes altering the use of occupancy of a licensed assisted living facility must be submitted to MDH Engineering for review and approval. O-D stated they were not aware of the Minnesota Department of Health approval requirement and verified this deficient condition, and the work was done without MDH review and prior approval.</p> <p>During the same interview, O-D also stated they would look for the inspection record from the city, and the record would be provided via email as a follow-up. But no follow-up email has been received from the facility.</p> <p>During the interview, O-D verified this deficient condition and stated that they would submit the required document to MDH for approval and inspection.</p>	0 830		

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0 830	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 830		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p>	01500		

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01500	<p>Continued From page 18</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee unlicensed personnel (ULP)-B.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p>	01500		

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01500	<p>Continued From page 19</p> <p>ULP-B was hired on April 22, 2022, to provide direct care services to residents.</p> <p>On September 10, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications to R2.</p> <p>ULP-B's record lacked evidence annual training had been completed as required in the following areas:</p> <ul style="list-style-type: none"> - Review of provider's policies and procedures. <p>On September 11, 2024, at 12:19 p.m., housing manager (HM)-A stated that the staff do not review all of the facilities policies and procedures annually but they do review some of the policies and always complete a policy review if an incident happens.</p> <p>The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated the following elements MUST be included every 12 months to all staff who performs direct care services:</p> <ul style="list-style-type: none"> - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of infection control techniques used in the home and implementation of infection control standards; - Effective approaches to use to problem solve when working with a residents challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders; - Review of the facilities policies and procedures relating to the provision of assisted living services 	01500		

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01500	Continued From page 20 and how to implement those policies and procedures; and - The 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	01500		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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01640	<p>Continued From page 21</p> <p>Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on services provided for one of one resident (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On September 10, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications to R2.</p> <p>R2's Service Recap for August 2024, indicated R2 received the following services:</p> <ul style="list-style-type: none"> - safety check - bathing reminder - daily grooming and dressing - housekeeping - transportation assistance - manage behavior - other mental health need - manage behavior - verbal aggression - manage behavior - agitation - manage behavior - anxiety - manage behavior - auditory hallucination - meal reminder - medication administration four times daily - socialization <p>On September 10, 2024, at 2:10 p.m., housing</p>	01640		
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01640	<p>Continued From page 22</p> <p>manager (HM)-A stated the resident's do not currently have a signed service plan due to using the master care plan and the Department of Health Services (DHS) worksheet together and thought this met the regulation.</p> <p>The licensee's Service Plan policy dated August 1, 2021, indicated an individualized Service plan is implemented for all residents. The licensee will provide all services required by the current Service plan. The Service plan includes the following:</p> <ul style="list-style-type: none"> - a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; - the fees for services and the frequency of each service according to the residents current review or assessment and resident preferences; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; - a contingency plan that includes the following: <ul style="list-style-type: none"> - action to be taken if the scheduled service cannot be provided; - information and method for a resident or residence 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 an information as to who has the authority to sign for the resident in an emergency; and - circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to 	01640		

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01640	Continued From page 23 health care directives. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Type: Full
Date: 09/09/24
Time: 10:19:20
Report: 8058241234

Food and Beverage Establishment Inspection Report

Page 1

Location:

Grace Group Home Llc
3538 Fremont Avenue North
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:

ID #: 0037685
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125989923
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

OPENED DELI ITEMS, CUT VEG AND FRUIT NOT MARKED WITH DATE

Comply By: 09/09/24

2-100 Supervision

2-102.12AMN

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

CERTIFIED FOOD MANAGER TRAINING NEEDED (CLASS FINDER DEMONSTRATED DURING INSPECTION)

Comply By: 11/29/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

MOUSE DROPPINGS NOTED IN CABINETS, CLEAN INTERIORS OF CABINETS AND REMOVE PACKING MATERIAL FROM BASE OF CHEST FREEZER

Comply By: 09/20/24

Type: Full
Date: 09/09/24
Time: 10:19:20
Report: 8058241234
Grace Group Home Llc

Food and Beverage Establishment Inspection Report

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

DISCARDED: SEVERAL GREEN POTATOES FROM COOLER

Comply By: 09/09/24

Food and Equipment Temperatures

Process/Item: CHEESE

Temperature: 40 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Process/Item: SALMON

Temperature: 40 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Process/Item: POTATO MIX

Temperature: 41 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

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

RESIDENTIAL KITCHEN, NON COMMERCIAL APPLIANCES AND FINISHES

DISH WASHER IS NOT IN USE

HRD INSPECTOR: SARABETH REMKER

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 8058241234 of 09/09/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Aaron Gertz

Sanitarian 3

MDH Metro Office

651 201 4500

health.foodlodging@state.mn.us