DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

October 26, 2026

Licensee
Grace Assisted Living LLC
13439 Granada Avenue
Apple Valley, MN 55124

RE: Denial of License Number 419644
Health Facility Identification Number (HFID) 41217
Initial survey; Project Number(s) SL41217015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 22, 2026 compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBILE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

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

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jodi Johnson, via email at: Jodi.Johnson@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **10/29/2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Jodi Johnson, Supervisor, at Jodi.Johnson@state.mn.us. Jodi Johnson can also be reached by office phone at 507-344-2730.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41217015-0 On September 21, 2026, through September 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 690	Continued From page 1	0 690		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and started services on June 1, 2026, with diagnoses including bipolar disorder, post-traumatic stress disorder (PTSD) and anxiety. R1's Service Plan dated June 1, 2026, indicated services included medication administration. R1's medication administration records (MARs) dated June, July, August, and September 2026, included the first initial of the staff administering	0 690		

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0 690	Continued From page 2 the medication for each day/time administered. The MAR did not include the first and last name and title of each staff that had administered the medications. On September 22, 2026, at 10:07 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's MARs and stated they did not include the first/last name and title of the unlicensed personnel administering the medications and should have. The licensee's 2.37 Resident Record - Documentation policy effective August 1, 2026, indicated: 1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal	0 730		

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0 730	Continued From page 3 representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required content for one of one discharged resident (R2). 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: R2's start of care for services was February 3, 2026, and was discharged on April 4, 2026. R2's Service Plan dated February 3, 2026, indicated services provided included medication administration, housekeeping, laundry, and safety checks. R2's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status.	0 730		

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0 730	Continued From page 5 On September 22, 2026, at 10:07 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R2's discharge summary and stated it did not include the above required content. The licensee's 2.38 Resident Record - Information and Content policy effective August 1, 2026, indicated: Resident Records must include: 14. A discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death),	0 775		

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0 775	Continued From page 6 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days..	0 775		
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	0 780		

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0 780	Continued From page 7 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 790	Continued From page 8	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 21, 2026, for the specific violations related the physical environment under Minnesota	0 790		

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0 790	Continued From page 9 Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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:	0 800		

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0 800	Continued From page 10 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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 staff twice per year per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 11 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 12 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language for the licensee's one resident (R1). 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	0 950		

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	41217	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

(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
0 950	Continued From page 13 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: R1's Assisted Living Contract was signed on June 1, 2026. R1's Service Plan was signed on June 1, 2026. R1's contract and record lacked the following required content: - Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On September 21, 2026, at 12:35 p.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's contract and stated although it did include the opportunity to identify a designated representative, the language in the contract was not verbatim to the statute.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

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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
0 950	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by:	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

(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
01700	Continued From page 15 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for the licensee's one resident (R1), prior to providing medication management 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: During the entrance conference on September 21, 2026, at 11:42 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to the one resident receiving assisted living services. R1's diagnoses included bipolar disorder, post traumatic stress disorder (PTSD), and anxiety disorder. R1's Service Plan dated June 1, 2026, indicated services provided included medication administration. R1's medication administration record (MAR) dated September 2026, included the following medications: one antidepressant, one antipsychotic, two inhalers, one muscle relaxant, and two antihistamines.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

(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
01700	Continued From page 16 R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On September 22, 2026, at 10:07 a.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's record and stated the medication assessment did not include evidence of the above required content. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2026, indicated: POLICY: [The licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. 1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

(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
01760	Continued From page 17 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure PRN (as needed) medication had documentation of time given and effectiveness after administration for the licensee's one resident (R1). In addition, the licensee failed to document an explanation when a scheduled medication wasn't administered as prescribed for the licensee's 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 to the licensee and started services on June 1, 2026, with diagnoses	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

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01760	Continued From page 18 including bipolar disorder, post-traumatic stress disorder (PTSD) and anxiety. R1's Service Plan dated June 1, 2026, indicated services provided included medication administration. PRN medications R1's medication administration record (MAR) dated September 2026, included the following PRN medications: - diphenhydramine (antihistamine) 25 mg (milligrams) tab (tablet): Take one tablet by mouth 1 - 2 times a day as needed - Seroquel (antipsychotic) 50 mg tab: Take one tablet by mouth twice a day as needed The MAR indicated R1 had received the PRN diphenhydramine twice a day from September 1, 2026, thru September 21, 2026, and the PRN Seroquel once a day from September 1, 2026, thru September 21, 2026. R1's record did not include documentation of the time each dose was administered, why it was administered, or the effectiveness of the medication. Scheduled medications R1's MAR dated September 2026, indicated instructions for documenting routine medications which included: 2. Circle refused and omitted doses (explain on reverse). The MAR included the following routine scheduled medications: - Elavil (antidepressant) 25 mg tab: Take one tablet by mouth daily. The MAR indicated on September 3rd and 4th, R1 did not receive the medication, with no documented explanation as to why. - quetiapine (antipsychotic) 300 mg tab: Take one tablet by mouth every night at bedtime. The MAR indicated on September 3, 10, 13, 17, 18, 19, 20, 21, 2026, R1 did not receive the medication, with	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

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01760	Continued From page 19 no documented explanation as to why. - Robaxin (muscle relaxant) 500 mg tab: Take one tablet by mouth daily. The MAR indicated on September 3, 4, 21, 2026, R1 did not receive the medication, with no documented explanation as to why. On September 22, 2026, at 8:14 a.m. unlicensed personnel (ULP)-C reviewed R1's September 2026, MAR and stated she had not been documenting the time, reason, and effectiveness of a PRN medication when administered though had been trained to do this, "That's on me". ULP-C further stated she had not been documenting an explanation when a scheduled medication was refused or omitted. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy effective August 1, 2026, indicated: 5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: e. The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41217	A. BUILDING: _____ B. WING _____	09/22/2026

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01820	Continued From page 20 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for the licensee's 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 to the licensee and started services on June 1, 2026, with diagnoses including bipolar disorder, post-traumatic stress disorder (PTSD) and anxiety. R1's Service Plan dated June 1, 2026, indicated services provided included medication administration. R1's medication administration record (MAR) dated September 2026, included the following medications: - Elavil (antidepressant) 25 mg (milligrams) one tablet by mouth daily	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 21 - Flovent HFA (hydrofluoroalkane - a propellant - it pushes the liquid medicine out of the inhaler as a fine spray mist) 44 mcg (micrograms) inhale two puffs by mouth and into the lungs twice a day. - quetiapine (antipsychotic) 300 mg take one tablet by mouth every night at bedtime - Robaxin (muscle relaxant) 500 mg take one tablet by mouth daily -diphenhydramine (antihistamine) 25 mg take one tablet by mouth one to two times a day as needed - Seroquel (antipsychotic) 50 mg take one tablet by mouth twice a day as needed - Ventolin HFA inhale two puffs by mouth and into the lungs every four hours as needed for difficulty breathing - Vistaril (antihistamine) 25 mg take one capsule by mouth every 8 hours as needed R1's record included a Prescription Transfer Report from the pharmacy which included the above medications. R1's record lacked signed prescriber orders for all medications administered by the licensee. On September 22, 2026, at 10:07 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the transfer orders from the pharmacy was all they had for prescriber orders for R1. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy effective August 1, 2026, indicated: Prior to a ULP (unlicensed personnel) providing delegated medication administration and/or treatments/therapy, the following must occur: 3. The medications have current prescriber's orders on file. No further information was provided.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2).	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRACE ASSISTED LIVING LLC	13439 GRANADA AVENUE APPLE VALLEY, MN 55124

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01910	Continued From page 23 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: R2's start of care for services was February 3, 2026, and was discharged on April 4, 2026. R2's Service Plan dated February 3, 2026, indicated services provided included medication administration. R2's record did not include a reconciliation of medications upon discharge. During the entrance conference on September 21, 2026, at 12:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the one resident that discharged (R2) had left abruptly and took his medications with him when he left. LALD/RN-A further stated staff did not count and document the medications given to R2 per protocol at the time of discharge and should have. The licensee's 7.23 Medication Disposal policy effective August 1, 2026, indicated: Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 24 individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GRACE ASSISTED LIVING LLC
13439 Granada Avenue
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 41217

Risk:
License:
Expires on:
CFPM: Leslie Ann Huna
CFPM #: 14759; Exp: 12/23/2027

Inspection Info

Report Number: F7963261108
Inspection Type: Full - Single
Date: 9/22/2026 Time: 1:43:03 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS IS A RESIDENTIAL HOME THAT USES SAME DAY FOODSERVICE. A DISHWASHER IS USED TO WASH/RINSE/SANITIZE DISHES AND UTENSILS.

KITCHEN HAS LAMINATE FLOORING AND COUNTERTOPS, PAINTED CABINETS AND SMOOTH PAINTED CEILING.

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

I acknowledge receipt of the Metro District Office inspection report number F7963261108 from 9/22/2026

Sisay Hailu

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

GRACE ASSISTED LIVING LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F7963261108
Inspection Type: Full
Date: 9/22/2026
Time: 1:43:03 PM

Food Temperature: Product/Item/Unit: lactose free milk**; Temperature Process:**
Location: refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

GRACE ASSISTED LIVING LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F7963261108
Inspection Type: Full
Date: 9/22/2026
Time: 1:43:03 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 157 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41217015	**Date:** 9/21/2026
Facility Name: Grace Assisted Living LLC	
Facility Address: 13439 Granada Ave., St. Paul, MN 55124	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 4; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: No carbon monoxide protection was installed within the facility. Facility staff indicated that the smoke alarms also detected carbon monoxide, however the surveyor examined the alarms and there was no indication of carbon monoxide detection capabilities. All of the alarms present in the facility indicated they were solely capable of detecting smoke. User manuals for the devices likewise failed to indicate carbon monoxide detection capabilities. Appropriate carbon monoxide protection should be installed and maintained in the facility.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: A battery-operated smoke alarm was installed in the lower-level bedroom hallway on top of hardwired smoke alarm hardware. Wiring was present for a hardwired alarm, but no hardwired alarm was connected. Hardwired smoke alarms should be installed and maintained as hardwired in any location where they were present. All smoke alarms should be maintained with their power supply and should also be maintained as interconnected with all other smoke alarms installed in the facility.

4. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3, MSFC 1104.26.2, 1104.26.6.1]

   Comments: The egress windows in resident room 3 and resident room 4 were not readily openable to allow access in the event of an evacuation. Facility staff required significant time and effort to open the egress windows during the survey. The egress windows did not properly function and were not readily accessible. The windows should be repaired and maintained such that they open readily and are usable in event of an emergency.

5. Portable outdoor fireplaces shall be used in accordance with the manufacturer's instructions and shall not be operated within 15 feet (3048 mm) of a structure or combustible material [Minn. Stat. 144G.45 subd. 2; MSFC 307.4.3]

   Comments: A section of the rear deck approximately 18 inches in diameter was melted and damaged. The damaged section of the deck was discolored, with small pits and bubbles in the engineered wood that was consistent with heat exposure to the deck. A portable firepit was stored next to the porch and had a similar shape and size to the discolored and scorched section of the deck. The location of the fire pit was less than 15 feet from the deck and the building on the property. Facility Staff acknowledged the burns on the deck but indicated they were unaware of the cause of the damage. Facility staff indicated that it was probable that the fire pit caused the burns to the deck and that the fire pit had been used on the rear porch for bonfires. Use of a portable firepit on top of the deck is improper and unsafe and poses a risk of fire. The damaged portion of the deck should be replaced or repaired with any compromised material removed. All firepits and other outdoor fire receptacles should be used in accordance with manufacturer's instructions, at least 15 feet from existing structures, in compliance with local ordinances, and in a safe manner to prevent fire from spreading to combustible portions of the facility.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarms in the facility were tested during the survey and several smoke alarms failed to interconnect properly when tested. When the smoke alarm in the lower-level hallway was activated, only the smoke alarms in resident room 3, resident room 5, and the upper-level hallway sounded. Numerous other smoke alarms were present which did not sound when tested. All installed smoke alarms should be properly interconnected such that the activation of any one alarm causes all others to sound.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: A fire extinguisher was provided in the laundry room which was not maintained in proper condition. The extinguisher's pressure gauge indicated the extinguisher did not have adequate pressure. No record was provided of annual servicing or monthly inspections for the extinguisher. Facility staff indicated that the extinguisher was extra and was not meant to be used. All extinguishers provided in the facility should be maintained in operable condition with all required servicing and inspections. Inoperable extinguishers should be removed to avoid confusion during an emergency or returned to functional use and maintained in proper condition.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Several boards on the rear deck were not properly secured and were very loose. These boards were pulling up from the deck in some locations and posed a tripping hazard by making the deck

uneven and unstable to walk on. The deck should have all damaged portions removed or repaired and all boards should be maintained in a secure and stable condition.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP binder was not properly maintained and facility staff could not locate documents with steps for evacuation during the survey. The FSEP should be maintained such that staff has access to important documents for evacuation at all times for use in an emergency. The FSEP should be maintained with accurate and up to date plans and procedures for evacuation.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. The FSEP contained several different generic plans for staff actions during evacuation. Facility staff could not provide accurate and up to date staff action documentation to the surveyor. The FSEP should include site-specific staff actions for evacuation.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide resident actions for evacuation during a fire or similar emergency. No information regarding resident actions or policy for evacuation was included in the FSEP and no documentation was provided to the surveyor during survey. Facility staff emailed additional documentation to the surveyor later in the day that the survey was completed, but these documents were not site-specific and adequate resident actions. The FSEP should include site-specific resident actions for evacuation.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation of unique resident needs for evacuation. No procedures were provided to the surveyor that included procedures for resident evacuation that identified unique resident needs. No specific information was located in the FSEP during the survey. Facility staff emailed additional documentation to the surveyor, but no specific individualized unique or unusual resident needs were identified. Unique and unusual needs for evacuation should be documented and maintained as accurate for each resident to ensure those needs are adequately addressed in event of an emergency.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide record of employee training on fire safety and evacuation policies. No record of employee trainings on the FSEP was provided to the surveyor. Staff should receive training on hire and at least twice a year thereafter.

6. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide record of resident training on fire safety and evacuation policies. No record of resident trainings on the FSEP was provided to the surveyor. Trainings should be provided for residents at least once per year.