STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Avenue Rest Home	3956 Grand Avenue S0uth Minneapolis, MN 55409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident's right to be treated with respect and dignity for 1 of 3 residents (R1) when the facility conducted searches of R1's personal belongings/room without R1's or her representative ?s consent.Findings include:R1's admission Record dated 5/29/23 indicated R1's diagnoses included Major depressive disorder, suicidal ideation, anxiety disorder, psychosis, and schizoaffective disorder.R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 is completely independent with activities of daily living (ADLs) and had intact cognition.R1's care plan, dated 4/28/25, indicated R1 drinks alcohol when under stress and got into a fight with peer. Staff interventions included random room/personal effect searches when indicated and as needed.R1's treatment administration record (TAR) dated 6/25/25, included and order to checks/searches R1's room for for alcohol (ETOH). The TAR indicated for nursing staff conducted R1's room searches on 10/1/2025 through 10/15/25. In review of R1's record did not include R1 or R1's representative agreed to a voluntary search and understood the reason for the search. R1's medical record did not identify that any search resulted in finding alcohol or any illegal substances. On 10/9/25 at 9:47 p.m., a progress note indicated nursing staff conducted a search in R1's room to make sure no ETOH (the type of alcohol found in alcoholic beverages) was stored. The note also indicated R1 had signs and symptoms of being intoxicated this evening.On 10/10/25 at 5:22p.m., a progress note indicated R1 was found intoxicated upon arrival at the hospital.On 10/14/25 at 9:45 a.m., a progress note indicated nursing staff followed up with R1 regarding drinking and R1 refused to sign a contract agreement.On 10/16/25 at 9:20 a.m., R1 stated she was independent for ADLs and did not want to talk to the facility provider. R1 denied giving a consent/agreement to search her room to make sure alcohol was not stored. R1 stated she was not aware of her room being search for illegal substances and/or alcohol.On 10/16/25 at 12:39 p.m., a registered nurse (RN)-A stated R1's room search was discussed during an interdisciplinary meeting, and it was entered into the medical record as nursing order. RN-A did not notify the physician about R1's room search nursing order. RN-A stated staff searched R1's room daily and had to document completion. RN-A could not find R1's consent to a voluntary search in her medical record.On 10/16/25 at 2:40 p.m., RN-B stated she searched R1's room at the beginning of her shift to make sure R1 was not hiding any alcohol. Nursing staff were expected to document room search completion in the TAR. RN-B stated she never found any illegal substances during R1's room search. RN-B was not aware if R1 had signed an agreement to a voluntary search.On 10/16/25 at 1:27 p.m., a licensed social worker (LSW)-A stated the interdisciplinary team discussed adding room searches for alcohol to R1's care plan. LSW-A stated the illegal substance policy said to notify the local law enforcement unless there was an immediate danger which was not R1's case. LSW-A stated R1 did not sign an agreement to a voluntary room search and added she did not know if nursing was doing room searches daily.On 10/16/25 at 10:53 a.m., a medical director (MD)-A stated she was not aware of a room search order request from the facility. MD-A stated when the facility requested a verbal order, she will send one of her medical team members to the facility to verify if the request was reasonable. MD-A could not find (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Avenue Rest Home	3956 Grand Avenue S0uth Minneapolis, MN 55409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything in her system which suggested R1's room search was needed.On 10/16/25 at 2:14 p.m., MD-B stated searching resident's room was not part of the facility's standing orders. MD-B stated attending physician give an order for searching resident's room in regard to the substance abuse policy.On 10/16/25 at 4:09p.m., the director of nursing (DON) stated she expected nursing staff to follow the facility substance abuse policy. The DON stated with R1's alcohol intoxication signs and symptoms, nurses updated the care team to include the intervention to make sure no alcohol was stored. The DON was not aware if staff have had ever found an illegal substance and/or alcohol in R1's room. The DON stated R1 was aware of her room search, however could not find any documentations about when R1 agreed to a voluntary search and the reason for the search.According to the State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, revision 229, issued 4/25/25, If the facility determines through observation that a resident may have access to illegal substances that they have brought into the facility or secured from an outside source, the facility should not act as an arm of law enforcement. Rather, in accordance with state laws, these cases may warrant a referral to local law enforcement. The facility staff should not conduct searches of a resident or their personal belongings unless the resident, or resident representative agrees to a voluntary search and understands the reason for the search.The facility policy for Alcohol and Chemical dated 2/13/25 directed nursing to notify the resident primary physician, guardian, and/or responsible party if substance used is suspected. The policy indicated resident room, and personal searches will only be conducted with resident consent, unless there is an immediate safety concern and law enforcement may be contacted as required by law.