DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 1, 2023

Licensee
Saint Ann's Home
330 East 3rd Street
Duluth, MN 55805

RE: Initial License Number 408889
Health Facility Identification Number (HFID) 30434
Project Number(s) SL30434015

Dear Licensee:

On January 25, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed October 21, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 31, 2023.

Furthermore, the follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the October 21, 2022, initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 21, 2022, found not corrected at the time of the January 25, 2023, follow-up evaluation and subject to a penalty assessment are as follows:

1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)
1530-Training In Dementia Care Required-144g.64
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1890-Prescription Drugs-144g.71 Subd. 20 - $500.00
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

The details of the violations noted at the time of this follow-up evaluation completed on January 25, 2023, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. The licensee is not required to submit a plan of correction 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).

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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 the Department of Health within 15 calendar days of the correction order receipt date. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jessica Chenze at 218-332-5175.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	R 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30434015 On January 24, 2023, through January 25, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 21, 2022. At the time of the survey, there were 89 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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	{0 780}		

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{0 780}	Continued From page 2 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{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: No further action required.	{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,	{0 800}		

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{0 800}	Continued From page 3 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: No further action required.	{0 800}		
{0 810} SS=F	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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	{0 810}		

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{0 810}	Continued From page 4 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	{01370}		

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{01370}	Continued From page 5 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of three employees (unlicensed personnel (ULP)-E and ULP-Q). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on	{01370}		

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{01370}	Continued From page 6 August 1, 2021. R14's Service Delivery Record for January 2023, indicated ULP-E provided direct care services to R14 on January 1 and 18, 2023. ULP-E's employee record lacked evidence ULP-E had received the following training and competency: - basic nutrition, meal preparation, food safety, and assistance with eating; and - preparation of modified diets as ordered by a licensed health professional. On January 24, 2023, at 2:00 p.m., business office manager (BOM)-M confirmed ULP-E's employee record lacked evidence ULP-E had not received training on basic nutrition, meal preparation, food safety, and assistance with eating; and preparation of modified diets as ordered by a licensed health professional. ULP-Q ULP-Q was contracted by the licensee on November 22, 2022, to provide direct care services to residents of the assisted living facility. On January 24, 2023, at 11:00 a.m. director of nurses (DON)-B stated ULP-Q had been scheduled to provide direct care services. ULP-Q's employee record contain documentation from the contracting agency indicating ULP-Q had completed the Certified Nursing Assistant Assessment Test on September 15, 2022; however, ULP-Q was not listed on the registery for CNA. The test covered topics related to safely performing activities of daily living (ADLs), measuring and documenting vital signs, finger stick blood glucose, and I & O (intake and	{01370}		

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{01370}	Continued From page 7 output). The test also includes topics on body, mechanics, basic medical terminology, skin care, and additional knowledge, skills, and abilities needed for successful job performance by a CNA (certified nursing assessment) in the acute care setting. ULP-Q's employee record lacked evidence ULP-Q had received the following training and competency: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; and - preparation of modified diets as ordered by a licensed health professional. On January 25, 2023, at 2:00 p.m., BOM-M confirmed ULP-Q had not received the training as indicated above. The licensee's 5.02 Competency Training Evaluation policy dated January 19, 2023, indicated training and competency evaluations for all ULP's will include: - Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting;	{01370}		

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{01370}	Continued From page 8 -Training on the prevention of falls; - Standby assistance techniques and how to perform them; - Medication, exercise, and treatment reminders; - Basic nutrition, meal preparation, food safety, and assistance with eating; and - Preparation of modified diets as ordered by a licensed health professional. No further information was provided.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of three employees (unlicensed personnel (ULP)-Q).	{01380}		

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{01380}	Continued From page 9	{01380}		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-Q
ULP-Q was contracted by the licensee on November 22, 2022, to provide direct care services to residents of the assisted living facility.

On January 24, 2023, at 11:00 a.m. director of nurses (DON)-B stated ULP-Q had been scheduled to provide direct care services.

ULP-Q's employee record contain documentation from the contracting agency indicating ULP-Q had completed the Certified Nursing Assistant Assessment Test on September 15, 2022; however, ULP-Q was not listed on the registery for CNA. The test covered topics related to safely performing activities of daily living (ADLs), measuring and documenting vital signs, finger stick blood glucose, and I & O (intake and output). The test also includes topics on body, mechanics, basic medical terminology, skin care, and additional knowledge, skills, and abilities needed for
successful job performance by a CNA (certified nursing assessment) in the acute care setting.

ULP-Q's employee record lacked evidence ULP-E had received demonstrated competency in

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{01380}	Continued From page 10 the following areas: - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On January 25, 2023, at 2:00 p.m., BOM-M confirmed ULP-Q had not received the training as indicated above. The licensee's 5.02 Competency Training Evaluation policy dated January 19, 2023, indicated training and competency evaluations for all ULP's will include: -reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. No further information provided.	{01380}		
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics	{01530}		

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{01530}	Continued From page 11 specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of four direct-care employees (director of nurses (DON)-B, registered nurse (RN)-C,) completed at least eight hours of initial dementia training with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DON-B DON-B started employment on February 3, 2020,	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	R 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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{01530}	Continued From page 12 under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey DON-B was observed to provide supervision to ULP. DON-B's employee record indicated DON-B had completed seven (7) hours of dementia training. RN-C RN-C started employment on May 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2023, at 11:00 a.m., DON-B stated RN-C updated resident records, when the residents received new prescriber's orders. RN-C's employee record indicated RN-C had completed four (4) hours of dementia training. On January 24, 2023, at 2:00 p.m., business office manager (BOM)-M confirmed DON-B, and RN-C, had not completed the required eight (8) hours of dementia training. BOM-M confirmed DON-B, and RN-C, had worked greater than 80 hours for the licensee. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided.	{01530}		

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{01650}	Continued From page 13	{01650}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plans included the required content for one of four residents (R1).	{01650}		

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{01650}	Continued From page 14 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's service plan dated January 9, 2023, indicated R1 received the following services: medication management, laundry, housekeeping and blood glucose monitoring. R1's service plans lacked the following required content: -the identification of staff or categories of staff who would provide the services for blood glucose monitoring. On January 25, 2023, at 9:00 a.m., director of nurses (DON)-B stated R1's service plans did not identify staff who would provide blood glucose monitoring. The licensee's 6.08 Service Plan policy dated January 18, 2023, indicated service plans will include: - an identification of staff or categories of staff who will be providing services. No further information was provided.	{01650}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	{01890}		

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{01890}	Continued From page 15 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for R10, R16, and R17. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 24, 2023, at 12:49 p.m., the evaluator observed the medication cart for floors one through three which was stationed on the first floor with unlicensed personnel (ULP)-E. ULP-E confirmed the following: -R10's opened Lantus Solostar insulin pen (long-acting insulin to control high blood sugar) lacked the date the insulin pen had been opened and when the insulin pen would expire. -R16's opened Humalog Kwik insulin pen (fast-acting insulin) lacked the date the insulin pen had been opened and when the insulin pen would expire.	{01890}		

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{01890}	Continued From page 16 -R17's opened Humalog Kwik and Lantus Solostar insulin pens lacked the date the insulin pens had been opened and when the insulin pens would expire. The manufacturer's instructions for Lantus insulin pen dated December 2020, indicated Lantus insulin can be stored for up to 28 days at room temperature after opened, then discarded. The manufacturer's instructions for Humalog insulin pen dated November 2019, indicated Humalog insulin can be stored for up to 28 days at room temperature after opened, then discarded. On January 24, 2023, at 12:58 p.m., director of nurses (DON)-B confirmed staff should be writing the date the insulin was opened on the labels. DON-B stated the licensee have been training staff on the process of dating time-sensitive medications and have been completing audits on the medications carts to ensure staff were dating time-sensitive medications after being opened. The licensee's Medication Storage policy dated January 19, 2023, indicated when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. No further information was provided.	{01890}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	{01960}		

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{01960}	Continued From page 17 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatments for one of two residents (R14). 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: R14's diagnoses included bipolar disorder and prostrate problems. R14's service plan and planned services dated November 11, 2022, indicated R14 was to receive catheter care six (6) times a day. R14's Service Delivery record for January 2023, indicated the ULP (unlicensed personnel) documented the services as follows -catheter care one hundred and seven (107) out of one hundred and forty-four (144) opportunities.	{01960}		

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{01960}	Continued From page 18 On January 25, 2023, at 9:00 a.m., director of nurses (DON)-B confirmed R14's catheter care was not performed as indicated by the above documentation. The licensee's 2.38 Resident Record-Information and Content policy dated January 13, 2023, indicated the resident's record must include documentation that services have been provided as identified in the service plan. No further information was provided.	{01960}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 15, 2022

Administrator
Saint Ann's Home
330 East 3rd Street
Duluth, MN 55805

RE: Conditional License Number 408889
Health Facility Identification Number (HFID) 30434
Project Number(s) SL30434015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on October 21, 2022, for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **February 13, 2023**.

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

Imposition of Fines
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Documentation of Action to Comply
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
b. Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
c. 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §626.557. Please email general reconsideration requests to: Health.HRD.Appeals@state.mn.us.

Requesting a Hearing
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing (but not both) under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15
business days of the correction order.

Conditional License Issued
MDH will issue Saint Ann's Home a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Saint Ann's Home is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Saint Ann's Home will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Saint Ann's Home must provide the Department:

    i. A list of the names and birthdates of any individuals Saint Ann's Home is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Saint Ann's Home will contract with an RN to provide consultation concerning all resident(s) to whom Saint Ann's Home provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Saint Ann's Home. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Saint Ann's Home and MDH must review the RN's credentials and approve the selection. Saint Ann's Home is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Saint Ann's Home in an effort to help Saint Ann's Home align their

practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Saint Ann's Home will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Saint Ann's Home and the RN consultant about a change. Each report will be electronically submitted to Jessica Chenze, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Saint Ann's Home to correct the violations cited during the evaluation as well as to determine the overall practice of Saint Ann's Home in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Saint Ann's Home will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern

iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period
MDH will determine if Saint Ann's Home is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Saint Ann's Home is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Saint Ann's Home's assisted living facility license, and Saint Ann's Home will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Saint Ann's Home is not in substantial compliance, MDH may take additional enforcement action against Saint Ann's Home, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division HHH

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	30434	A. BUILDING: _____ B. WING _____	10/21/2022

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0 000	Initial Comments 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: SL#30434015 On October 17, 2022, through October 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 95 residents, 70 receiving services under the provider's Assisted Living license. Immediate correction orders were identified on October 18, 2022 and October 20, 2022, issued for SL30434015, tag identification 1750 and 2310. On October 19, 2022, the immediacy of order 2310 was removed, and on October 21, 2022, immediacy of order 1750 was removed, however non-compliance remains at a scope and level of I for 2310 and G for 1750.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

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SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 17, 2022, at approximately 9:30 a.m., upon entrance, LALD-A indicated he was the LALD for the facility. LALD-A obtained an assisted living director license on June 23, 2021. On October 17, 2022, at 8:00 a.m., the BELTSS website indicated LALD-A held a current assisted living director license. The BELTSS website did	0 110		

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	30434	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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0 110	Continued From page 2 not identify LALD-A as the Director of Record for the licensee. On October 17, 2022, at 9:30 a.m., LALD-A states he was not listed as the Director of Record for the licensee. LALD-A stated he was not aware of the requirement for the Director of Record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees;	0 250		

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0 250	Continued From page 3 (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250		

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0 250	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022, at approximately 10:35 a.m.., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.	0 250		

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0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted	0 250		

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0 250	Continued From page 6	0 250		

are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.

- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.

Page five was electronically signed by licensed assisted living director (LALD)-A on May 23, 2022.

The licensee had an assisted living license issued on August 1, 2022, with an expiration date of October 31, 2023.

The licensee failed to ensure the following policies and procedures were implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating

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0 250	Continued From page 7 staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) infection control practices; (4) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (5) medication and treatment management; (6) delegation of tasks by registered nurses or licensed health professionals; On October 21, 2022, at 1:45 p.m., director of nursing (DON)-B confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0470, 0480, 0630, 0650, 0660, 0680, 0730, 0780, 0790, 0800, 0810, 09020, 0930, 0940, 0970, 1060, 1350, 1370, 1380, 1470, 1500, 1530, 1620, 1650, 1700, 1750, 1760, 1790, 1880, 1890, 1910, 1950, 1960, 2310, 2320, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 470	Continued From page 8	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was developed, potentially affecting all ninety-five (95) residents in the assisted living facility, staff and any visitors of the licensee.	0 470		

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0 470	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit; and staff experience, training, and competency. On October 31, 2022, during the entrance conference at 9:30 a.m., licensed assisted living director (LALD)-A and director of nursing (DON)-B stated they post the daily staffing schedule. behind the front desk. DON-B stated she was not familiar with this regulation and had not developed a staffing plan. The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2022, indicated the clinical nurse supervisor will develop and implement a written	0 470		

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0 470	Continued From page 10 staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all seven (7) residents.	0 480		

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0 480	Continued From page 11 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 included document titled, Food and Beverage Establishment Inspection Report dated October 17, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 630		

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0 630	Continued From page 12 licensee failed to ensure an individual abuse prevention plan was developed to include the required content for five of six residents (R3, R5, R6, R8, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. R3's Individual Abuse Prevention Plan dated September 17, 2022, lacked an individual review or assessment of R3's susceptibility to abuse other individuals, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. R5 R5's diagnoses included atrial fibrillation (irregular heartbeat). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management, laundry, and housekeeping.	0 630		

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0 630	Continued From page 13 R5's Individual Abuse Prevention Plan dated September 20, 2022, lacked an individual review or assessment of R5's susceptibility to abuse other individuals, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. R6 R6's diagnoses included, malignant neoplasm of the left breast. R6's service plan dated July 28, 2022, indicated R6 received the following services: A.M. and P.M. cares, medication management, laundry and housekeeping. R6's Individual Abuse Prevention Plan dated July 28, 2022, lacked an individual review or assessment of R6's susceptibility to abuse other individuals. R7 R7's diagnoses included, chronic arterial tribulation. R7's service plan dated September 7, 2022, indicated R2 received the following services: compression stockings, housekeeping, laundry, and medication administration. R7's Individual Abuse Prevention Plan dated August 11. 2022, lacked an individual review or assessment of R7's susceptibility to abuse other individuals, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the	0 630		

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0 630	Continued From page 14 risk of abuse. R9 The licensee's Current Resident Roster indicated R9 only received housing services beginning on April 26, 2019. R9's Individual Abuse Prevention Plan dated February 22, 2022, lacked an individual review or assessment of R9's susceptibility to abuse other individuals, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. On October 214, 2022, at 1:45 p.m. director of nursing (DON)-B stated R3, R5, R6, R7 and R9's Abuse Prevention Plans lacked an individual review or assessment of R3, R5, R6, R7 and R9's susceptibility to abuse other individuals, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. No further information provided.	0 630		

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0 630	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 16 by: Based on observation, interview, and record review the licensee failed to ensure annual perform reviews were completed for four of four employees (director of nursing (DON-B), registered nurse (RN)-C, unlicensed personal (ULP)-E, ULP-F). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DON-B DON-B started employment on February 3, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey DON-B was observed to provide supervision to ULPs. DON-B's employee record lacked evidence annual performance review had been completed. RN-C RN-C started employment on May 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R6 and R7's records indicated RN-C completed	0 650		

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0 650	Continued From page 17	0 650		

assessments remotely on July 28, 2022, and September 7, 2022, respectively.

RN-C's employee record contained an annual performance review dated May 2, 2019.

ULP-E
ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications.

ULP-E's employee record lacked evidence an annual performance review had been completed.

ULP-F
ULP-F started employment on August 8, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On October 18, 2022, at approximately 7:06 a.m., the surveyor observed ULP-F administer R12's morning medications.

ULP-F's employee record contained an annual performance review dated August 8, 2021.

On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed DON-B, RN-C, ULP-E and ULP-F's employee records lacked evidence an annual performance review had been completed.

The licensee's 4.05 Employee Record policy dated August 1, 2021, indicated the employee

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0 650	Continued From page 18 records would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed ensure a TB Risk Assessment was completed and failed to ensure a TB history and symptom screen were	0 660		

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0 660	Continued From page 19 completed for two of six employees (director of nursing (DON)-B and unlicensed personnel (ULP)-G) and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of six employees (DON-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT During the entrance conference on October 17, 2021, at approximately 9:30 a.m. the surveyor asked the licensed assisted living director (LALD)-A and DON-B to provide the TB Risk assessment. On October 17, 2022, at approximately 4:50 p.m., the surveyor again requested the licensee's TB Risk Assessment. On October 20, 2022, at approximately 8:15 a.m., the surveyor again requested the licensee's TB Risk Assessment. The licensee never provided the TB Risk Assessment. On October 21, 2022, at approximately 1:45 p.m., DON-B confirmed a TB Risk assessment had not been completed.	0 660		

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0 660	Continued From page 20 TB HISTORY AND SYMPTOM SCREEN AND/OR TST MONITORING DON-B DON-B started employment on February 3, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey DON-B was observed to provide supervision to ULP. DON-B's employee record lacked evidence a TB history and symptom screen and TST had been completed. ULP-G ULP-G was hired on October 11, 2022, to provide assisted living services. The licensee's weekly schedule for the week of October 17, 2022, indicated ULP-G was scheduled to work on October 17, 18, and 19, 2022. DON-B confirmed ULP-G did work on October 17, 18, and 19, 2022. ULP-G's employee record lacked evidence a TB history and symptom screen had been completed. On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed DON-B and ULP-G's employee record lacked evidence DON-B had completed a TB history and symptom screen and two-step TST and ULP-G lacked a TB history and symptom screen. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated the facility will maintain a current community TB risk	0 660		

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0 660	Continued From page 21 assessment. Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 22 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 17, 2022, at 9:52 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. The licensee's EPP lacked the following content: - process for EP cooperation with state and local EP officials/organizations; - development of policies/procedures to address: - procedure for tracking staff and residents; -procedure to address use of volunteers, including process/for integration; -procedure address: development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; -subsistence needs for staff and residents	0 680		

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0 680	Continued From page 23 during an emergency to include (food, water supplies, sewer and waste disposal); and - a communication plan that included: - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; and -emergency prep testing and requirements to include participation in full-scale or table-top exercises. On October 21, 2022, at 2:00 p.m., administrative assistant (AA)-L stated she was responsibility for maintaining the EPP. The surveyor and AA-L reviewed the EPP and AA-L was unable to locate topics indicated above in the EPP. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 representatives, and designated representative;	0 730		

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0 730	Continued From page 24 (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 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for one of four residents (R6) and failed to ensure a discharge summary was completed for one of one resident (R11). 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: DOCUMENTATION OF SERVICES R6 R6's service plan dated July 28, 2022, indicated services included medication administration, morning (A.M.) and evening (P.M.) Cares, Wellness checks two (2) hours monthly, and laundry. R6's Service Recap Summary for September 2022, indicated the unlicensed personnel (ULP) documented the services as follows: -A.M. Care sixteen (16) out of thirty (30) opportunities; -P.M. Care seventeen (17) out of thirty opportunities; -laundry two (2) out of four (4) opportunities; and -Wellness checks zero out of one (1) opportunity.	0 730		

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0 730	Continued From page 26 R6's Service Recap Summary for October 2022, indicated the ULP documented the services as follows: -A.M. Care four-teen (14) out of eight-teen (18) opportunities; and -P.M. Cares seven-teen (17) out of eight-teen opportunities. R6's Service Delivery Record for June 2022, indicated the unlicensed personnel (ULP) documented the services as follows: -activity assistance fifteen (15) out of 30 opportunities; -ambulation thirty-four (34) out of 90 opportunities; -bathing four (4) out of eight (8) opportunities; -dressing fifty-three (53) out of sixty (60) opportunities; -grooming seventeen (17) out of sixty (60) opportunities; -housekeeping fifteen (15) out of thirty (30) opportunities; and -laundry one (1) of four (4) opportunities. R6's Service Delivery Record for July 2022, indicated the ULP documented the services as follows: -activity assistance nine (9) out of eleven (11) opportunities; -ambulation eighteen (18) out of thirty-three (33) opportunities; and -grooming nineteen (19) out of twenty-two (22) opportunities. On October 21, 2022, at 1:45 p.m., director of nurses (DON)-B stated R6's services were not documented as indicated above. DISCHARGE SUMMARY	0 730		

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0 730	Continued From page 27 On October 28, 2022, at approximately 9:52 a.m., during entrance conference, a list off the licensee's discharged residents was requested and later provided. The licensee's Discharge Resident/Client Roster list dated October 17, 2021, to October 17, 2022, indicated R11's services started May 7, 2018, and R11 deceased September 14, 2022. R11's diagnosed included diabetes, congestive heart failure, chronic kidney disease and long-term use of anticoagulants (medications used to thin the blood). R11's record lacked evidence a discharge summary was completed. On October 19, 2022, at approximately 10:40 a.m., DON-B provided the surveyor with R11's medical record and stated she was unable to find a discharge summary for R11. The licensee's 2.38 Resident Record-Information and Content policy dated August 1, 2021, indicated the resident's record must include documentation that services have been provided as identified in the service plan and discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 28 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 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 29 On October 19, 2022, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the operations director (OD)-K. During the facility tour, survey staff observed that when smoke alarms in resident apartments were tested by OD-X, none of the other alarms within the dwelling unit were activated. During the tour interview, OD-K confirmed that smoke alarms were not interconnected within dwelling units so that actuation of one alarm caused all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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 and interview, the licensee failed to maintain the portable fire extinguishers. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 30 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2022, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the operations director (OD)-K. During the facility tour, survey staff observed portable fire extinguishers with service tags that were punched with a date of September 2021. During the tour interview, OD-K confirmed that the portable fire extinguishers required annual maintenance. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 and interview, the licensee failed to provide 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	0 800		

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	30434	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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0 800	Continued From page 31 affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2022, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the operations director (OD)-K. During the facility tour, survey staff observed the following: 1. Hot water was not provided at the sink faucet in resident apartment 209. 2. The east elevator was not working. Signs were posted for the elevator that it was out of order. 3. The drinking water fountain on the second floor leaked water onto the wall and floor when turned on. The drinking water fountain had been posted with signage that it was out of order. During the tour interview, OD-K confirmed the findings. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	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;	0 810		

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	30434	A. BUILDING: _____ B. WING _____	10/21/2022

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0 810	Continued From page 32 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. 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	0 810		

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0 810	Continued From page 33 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2022, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the operations director (OD)-K. During the facility tour, survey staff observed that the location and number of resident sleeping rooms were not identified on the evacuation plans posted in the facility. During the tour interview, OD-K confirmed the findings. On October 19, 2022, at approximately 2:30 p.m., the OD-K and the assistant administrator (AA)-L provided documents for review. Documents were reviewed by survey staff on October 19, 2022, between 2:30 p.m. and 3:30 p.m. 1. The licensee provided employee training for fire safety and evacuation upon hire and annually but did not meet the twice per year after hire training frequency. 2. Fire drill reports for evacuation drills were provided for review. Evacuation drills had not been completed during the third shift. The evacuation drill frequency of twice per year per shift was not met. On October 19, 2022, at approximately 3:45 p.m., the OD-K and AA-L confirmed the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 920	Continued From page 34	0 920		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R3, R5). This had the potential to affect all 95 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 920		

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0 920	Continued From page 35 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: R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. R5 R5's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), depression, coronary artery disease (blockage or narrowing of the heart vessels). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management services to include medication set up. R3 and R5's Assisted Living Contract dated August 9, 2022, and July 18, 2022 respectively, lacked the following: -a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On October 21, 2022, at 2:14 p.m., assistant administrator (AA)-L stated the licensee was using the same Assisted Living Contracted noted above for all residents. The surveyor and AA-L reviewed the contract together and AA-L stated	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 36 the current Assisted Living Contract indicated on page one (1), the licensee was registered with the Minnesota Department of Health as an "Assisted Living Facility"; however, did not indicate the licensee was not licensed as an Assisted Living dementia care facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by:	0 930		

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0 930	Continued From page 37 Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R3, R5). This had the potential to affect all 95 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. R5 R5's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), depression, coronary artery disease (blockage or narrowing of the heart vessels). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management services to include medication set up. R3 and R5's Assisted Living Contract dated August 9, 2022, and July 18, 2022 respectively, lacked the following: -facility's policy regarding transfer of residents	0 930		

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0 930	Continued From page 38 within the facility, under what circumstances a transfer may occur and the circumstances under which resident consent is required for a transfer; and -contact information for the Ombudsman for Mental Health and Development Disabilities. On October 21, 2022, at 2:14 p.m., assistant administrator (AA)-L stated the licensee was using the same Assisted Living Contracted noted above for all residents. The surveyor and AA-L reviewed the contract together and AA-L verified the current Assisted Living Contract did not include the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay	0 940		

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0 940	Continued From page 39 privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R3, R5). This had the potential to affect all 95 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3	0 940		

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0 940	Continued From page 40 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. R5's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), depression, coronary artery disease (blockage or narrowing of the heart vessels). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management services to include medication set up. R3 and R5's Assisted Living Contract dated August 9, 2022, and July 18, 2022 respectively, lacked the following: -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -toll free number for (Minnesota Adult Abuse Reporting Center) MAARC. On October 21, 2022, at 2:14 p.m., assistant administrator (AA)-L stated the licensee was using the same Assisted Living Contracted noted above for all residents. The surveyor and AA-L reviewed the contract together and AA-L verified the current Assisted Living Contract did not include the contact information for MAARC. No further information was provided.	0 940		

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0 940	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 95 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 17, 2022, at 9:52 a.m., a request was made to view the licensee's assisted living contract, which was provided and later reviewed by the surveyor.	0 970		

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0 970	Continued From page 42 The assisted living contract provided included clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. On Page five (5), section nine (9), the license did not guarantee to have sufficient services available, and the licensee did not make available any services the resident would require for safe living. On page six (6) under Disclaimer, section 16, the resident would agree in the event the licensee did not supply housing and meals as a result of the occurrence of fire, flood, natural disaster, act of God, strike, war, civil disturbance or unavailability of food and fuel, the licensee shall have NO responsibility to supply housing or meals or to reimburse any resident for any cost incurred by said resident in obtaining substitute housing and/or meals. However, in the event that licensee did not supply such services, the rental and other charges to the resident will be reduced by the prorated portion of rent or other related charges that the period of failure to supply service bears to any period for which rent and related costs have been paid or are due to payable. On October 21, 2022, at 2:14 p.m., assistant administrator (AA)-L stated the licensee was using the same Assisted Living Contracted noted above for all residents. The surveyor and AA-L reviewed the contract together and AA-L verified the current Assisted Living Contract included the above language and stated the language had not been removed from the previous rental agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 44 a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to provide written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 17, 2022, at approximately 9:30 a.m., during the entrance conference, director of nursing (DON)-B stated R2 was in short term rehab after a hospitalization. R2's Progress Notes indicated the following: -October 6, 2022, at 1:13 p.m., R2 was sent to the ER (emergency room) on the 4th with lower extremity scaling rash that was blistered and weeping to the point that R2's pants legs were wet. R2 was admitted to 8 East. Resident is being treated for localized dermatitis and the blistering has improved. R2 does have pain with movement and a foley catheter was inserted. If no continued improvement with kenalog and ace wraps they plan to do a skin biopsy. Discharge plans have not been determined at this point. R2 is being	01060		

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01060	Continued From page 45 given a narcotic for pain control. R2 son contacted as he is concerned about R2's walker and TV (television) remote and this is being returned to R2's room. The licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums: -reason for relocation; -name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable the approximate date or range or dates within which the resident is expected to return or a statement the return date is unknown; -a statement if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144.54. The facility must provide contact information for the agency to which the resident may submit an appeal; -the notice must be delivered as soon as practicable to: -the resident, legal representative, and designated representative; -for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and -the Office of Ombudsman for Long-Term Care if the resident has been relocated. On October 17, 2022, at 9:30 a.m., licensed assisted living director (LALD)-A and DON-B stated they were not aware of the need to provide written notice with required content for an emergency relocation and the need to notify the	01060		

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01060	Continued From page 46 OOLTC of the emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the licensee for one of one contracted unlicensed personnel (ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was contracted by the licensee on October 17, 2022, to provide direct care services to residents of the assisted living facility.	01350		

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01350	Continued From page 47 The licensee's weekly schedule for the week of October 17, 2022, indicated ULP-H was scheduled to provide direct care services on October 19, 2022. On October 21, 2022, at 9:00 a.m., director of nurses (DON)-B confirmed ULP-H provided direct care services on October 19, 2022. ULP-H's employee record lacked evidence ULP-H had received training on the following required topics: Orientation Training: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01350		

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01350	Continued From page 48 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. Training and competency evaluations: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01350		

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01350	Continued From page 49	01350		

technology equipment and assistive devices.
(16) observing, reporting, and documenting resident status;
(17) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
(18) reading and recording temperature, pulse, and respirations of the resident;
(19) recognizing physical, emotional, cognitive, and developmental needs of the resident;
(20) safe transfer techniques and ambulation;
(21) range of motioning and positioning; and
(22) administering medications or treatments as required.

ULP-H's employee record also lacked evidence ULP-H had completed the TST (two-step tuberculin skin test).

On October 20, 2022, at 1:11 a.m., business office manager (BOM)-M confirmed ULP-H's employee record lacked the above required content.

The licensee's 4.08 Volunteer and Contract Records policy dated August 1, 2022, indicated Volunteer and contractor records for each person will include:
- Records of all training and in-service education required and/or provided
including record of competency testing as required;
- Current job description, which includes qualifications, responsibilities, and identification of supervisors, if any;
- For individuals providing Assisted Living services, verification that required
health screenings for Tuberculosis (TB) have taken place and the dates of

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01350	Continued From page 50 those screenings, (recommended to keep medical information in a separate employee medical file); and - Verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370		

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01370	Continued From page 51 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of three employees (unlicensed personnel (ULP)-E and ULP-G). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and	01370		

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01370	Continued From page 52 began providing assisted living services on August 1, 2021. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications. ULP-E's employee record lacked evidence ULP-E had received the following training and competency: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. ULP-G ULP-G was hired on October 11, 2022, to provide assisted living services. The licensee's weekly schedule for the week of October 17, 2022, indicated ULP-G was scheduled to work on October 17, 18, and 19, 2022. Director of nursing (DON)-B confirmed ULP-G provided direct care services on October 17, 18, and 19, 2022. ULP-G's employee record lacked evidence ULP-G had received the following training and	01370		

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01370	Continued From page 53 competency: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On October 20, 2022, at approximately 9:00 a.m., DON-B stated when ULP are hired they are given a packet of information pertaining to training. The ULP are to complete the packet of information and turn it in and then DON-B will review the	01370		

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01370	Continued From page 54	01370		

information that they turn in. DON-B stated ULP-G had not turned in her packet of information. DON-B stated because they are so short of staff, new ULP are paired up with another ULP and put out on the floor to work.

On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed ULP-E and ULP-G had not received the training as indicated above.

The licensee's 5.02 Competency Training Evaluation policy dated August 1, 2021, indicated training and competency evaluations for all ULP's will include:
- Documentation requirements for all services provided;
- Reports of changes in the resident's condition to the supervisor designated by
the facility;
- Basic infection control, including blood-borne pathogens;
- Maintenance of a clean and safe environment;
- Appropriate and safe techniques in personal hygiene and grooming, including:
i. hair care and bathing
ii. care of teeth, gums, and oral prosthetic devices
iii. care and use of hearing aids
iv. dressing and assisting with toileting;
-Training on the prevention of falls;
- Standby assistance techniques and how to perform them;
- Medication, exercise, and treatment reminders;
- Basic nutrition, meal preparation, food safety, and assistance with eating;
- Preparation of modified diets as ordered by a licensed health professional;
- Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural

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01370	Continued From page 55 background, and family; - Awareness of confidentiality and privacy; - Understanding appropriate boundaries between staff and residents and the resident's family; - Procedures to use in handling various emergency situations; and - Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and	01380		

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01380	Continued From page 56 competency evaluations included all the required training for two of three employees (unlicensed personnel (ULP)-E, ULP-G) with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications. ULP-E's employee record lacked evidence ULP-E had received the following training and competency: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-G ULP-G was hired on October 11, 2022, to provide	01380		

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01380	Continued From page 57 assisted living services. The licensee's weekly schedule for the week of October 17, 2022, indicated ULP-G was scheduled to work on October 17, 18, and 19, 2022. Director of nursing (DON)-B confirmed ULP-G provided direct care services on October 17, 18, and 19, 2022. ULP-G's employee record lacked evidence ULP-G had received the following training and competency. - Observing, reporting, and documenting resident status; - Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - Reading and recording temperature, pulse, and respirations of the resident; - Recognizing physical, emotional, cognitive, and developmental needs of the resident; -Safe transfer techniques and ambulation; - Range of motioning and positioning; and - Administering medications or treatments as required. On October 20, 2022, at approximately 9:00 a.m., DON-B stated when ULP are hired they are given a packet of information pertaining to training. The ULP are to complete the packet of information and turn it in and then DON-B will review the information that they turn in. DON-B stated ULP-G had not turned in her packet of information. DON-B stated because they are so short of staff, new ULP are paired up with another ULP and put out on the floor to work. On October 20, 2022, at 11:11 a.m., business	01380		

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01380	Continued From page 58 office manager (BOM)-M confirmed ULP-E and ULP-G had not received the training as indicated above. The licensee's 5.02 Competency Training Evaluation policy dated August 1, 2021, indicated training and competency evaluation for unlicensed personnel providing assisted living services must include: - Observing, reporting, and documenting resident status; - Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - Reading and recording temperature, pulse, and respirations of the resident; - Recognizing physical, emotional, cognitive, and developmental needs of the resident; -Safe transfer techniques and ambulation; - Range of motioning and positioning; and - Administering medications or treatments as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

(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
01470	Continued From page 59 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 60 incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for five of five employees (director of nurses (DON)-B), registered nurse (RN)-C, unlicensed personnel (ULP)-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: DON-B DON-B started employment on February 3, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-C RN-C started employment on May 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01470		

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01470	Continued From page 61 ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F ULP-F started employment on August 8, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. DON-B, RN-C, ULP-E, and ULP-F's employee records lacked the required orientation training to include the following topics: - an overview of this chapter; and - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. ULP-G ULP-G was hired on October 11, 2022, to provide assisted living services. ULP-G's employee records lacked the required orientation training to include the following topics: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff	01470		

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01470	Continued From page 62	01470		

responsibilities related to ensuring the exercise and protection of those rights;
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

On October 20, 2022, at 1:11 a.m., business office manager (BOM)-M confirmed DON-B, RN-C, ULP-E, ULP-F, and ULP-G had not completed the required orientation training as indicated above.In addition, BOM-M stated non of the licensee's employees received the following components of annual training: an overview of this chapter; and an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person.

The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated the orientation must contain the following topics:
- An overview of the appropriate Assisted Living statutes and rules;
- An introduction and review of the facility's policies and procedures related to the provision of

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01470	Continued From page 63 assisted living services by the individual staff person; - Handling of emergencies and use of emergency services; - Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 64 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: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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	01500		

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01500	Continued From page 65 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for four of four employees (director of nurses (DON)-B, registered nurse (RN)-C, unlicensed personnel (ULP)-E, and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: DON-B DON-B started employment on February 3, 2020, under the comprehensive home care license and began providing assisted living services on	01500		

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01500	Continued From page 66 August 1, 2021. RN-C RN-C started employment on May 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F ULP-F started employment on August 8, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. DON-B, RN-C, ULP-E, and ULP-F's employee records lacked annual training on the following required topic: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed DON-B, RN-C, ULP-E, ULP-F, and all employees had not completed the annual training as indicated above. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2022, indicated annual training included: a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.	01500		

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01500	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of	01530		

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01530	Continued From page 68 three direct-care employees (director of nurses (DON)-B, registered nurse (RN)-C, unlicensed personnel (ULP)-E) completed at least eight hours of initial dementia training with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DON-B DON-B started employment on February 3, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey DON-B was observed to provide supervision to ULP. DON-B's employee record indicated DON-B had completed six (6) hours of dementia training. RN-C RN-C started employment on May 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R6 and R7's records indicated RN-C completed assessments remotely on July 28, 2022, and September 7, 2022, respectively.	01530		

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01530	Continued From page 69 RN-C's employee record indicated RN-C had completed four (4) hours of dementia training. ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications. ULP-E's employee record indicated ULP-E had completed four (4) hours of dementia training. On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed DON-B, RN-C, and ULP-E, had not completed the required eight (8) hours of dementia training. BOM-M confirmed DON-B, RN-C, and ULP-E had worked greater than 80 hours for the licensee. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 70	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for two of two residents (R2, R13), and failed to ensure the ongoing resident reassessment did not exceed 90 days for one of four residents (R3). In addition, the RN failed to complete a comprehensive assessment by day 14 from admission for one of one resident (R5) as required. Further, the	01620		

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01620	Continued From page 71 licensee failed to ensure resident assessments were completed face to face with the resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CHANGE OF CONDITION R2 R2's diagnoses included CVA (cerebral vascular accident) memory loss, Multiple Sclerosis, and cellulitis. R2's Progress Notes indicated the following: -October 6, 2022, at 1:13 p.m., R2 was sent to the ER (emergency room) on the 4th with lower extremity scaling rash that was blistered and weeping to the point that R2's pants legs were wet. R2 was admitted to 8 East. Resident is being treated for localized dermatitis and the blistering has improved. R2 does have pain with movement and a foley catheter was inserted. If no continued improvement with Kenalog and ace wraps they plan to do a skin biopsy. Discharge plans have not been determined at this point. R2 is being given a narcotic for pain control. R2 son contacted as he is concerned about R2's walker and TV (television) remote and this is being returned to R2's room. -September 19, 2022, 90-day review completed, R2's condition is stable. Continue current care and service plan.	01620		

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01620	Continued From page 72 R2's assessment dated September 19, 2022, completed remotely by registered nurse (RN)-C indicated "Denies skin problems". R2's record lacked evidence a face-to-face assessment of R2's skin condition was completed on September 19, 2022. R2's record also lacked documentation pertaining to the rash on R2's leg until October 6, 2022, when R2 was sent to the emergency room. On October 19, 2022, approximately 8:30 a.m. the director of nursing (DON)-B confirmed there was no other documentation pertaining to the resident's hospitalization. DON-B stated R2 was at [name of facility] for short term rehabilitation. R13 R13's included diabetes mellitus, and dementia. R13's Progress Notes indicated the following: -October 12, 2022, at 10:34 p.m. (written by RN-C, remote RN), R13 was sent to the ER (emergency room) this morning following a fall and returned with the following: Your diagnosis is - Fall with a skin tear to the L (left) elbow, laceration to L face area, and hematoma to the L jaw. Return to ER for headache, numbness or tingling, confusion, inappropriate drowsiness, nausea, or vomiting, if symptoms worsen or for any concerns. No changes to medications. Major procedures performed during ER visit, laceration repair, dissolving stitches. If the stitches do not fall out in 14 days make an appointment with PCP (primary care physician) for removal. R13's Resident Incident Report, dated October 12, 2022, at 6:30 a.m., indicated R13 was trying to use the bathroom and R13 slipped and fell.	01620		

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01620	Continued From page 73 There was a laceration on R13's left elbow and left side of face. R13 was taken by ambulance to the hospital at 7:00 a.m. DON-B was notified at 9:00 a.m. DON-B entered a follow-up note (not dated): R13 was sent to the hospital by ambulance. R13 returned with orders to have stitches removed and return if increased pain. See note in computer. The most recent assessment in R13's record was dated August 15, 2022, and was completed remotely by RN-C. R13's record lacked evidence the RN conducted reassessment of R13 following R13's return from the ER. R13's record lacked evidence the RN had completed a reassessment of R13's fall for causative factors to determine individualized interventions to reduce the resident's risk for injury from falls. On October 21, 2022, at 1:45 p.m., DON-B stated the RN did not reassess R13 upon return from the ER and did not reassess R13's fall for causative factors to determine individualized intervention to reduce the resident's risk of injury from falls. DON-B stated that all resident assessments are completed by RN-C remotely. DON-B stated is RN-C does not use telecommunication or talk with the resident. If RN-C had questions she would communicate with DON-B. TIMELY ASSESSMENTS R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication	01620		

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01620	Continued From page 74 management, blood glucose monitoring, grooming, personal cares, and laundry. R3's record indicated the RN completed a 90-day assessment (remotely) on June 18, 2022, and September 17, 2022, which exceeded 90 days from the previous completed assessment by one (1) day. R5 R5's diagnoses included atrial fibrillation (irregular heartbeat). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management, laundry, and housekeeping. R5's record indicated the RN completed an initial assessment (remotely) on March 23, 2022, and June 22, 2022, which exceeded 14 days from the previous completed assessment by one (1) day. On October 21, 2022, at 1:19 p.m., DON-B confirmed R3's 90-day assessment and R5's 14-day assessment were completed remotely by RN-C and had not been completed within the required time frame. The licensee's 6.02 Assessment Schedule policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services and ongoing reassessment and monitoring as needed based on changes in the needs of the resident but can not be conducted more than 90 calendar days from the last date of the assessment. The assessments are to be performed in-person or via telecommunications if necessitated by geographic distance or urgent/unexpected circumstances.	01620		

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01620	Continued From page 75 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 76 by: Based on observation, interview and record review, the licensee failed to ensure the service plans included the required content for four of four residents (R3, R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. On October 17, 2022, at 12:02 p.m., unlicensed personnel (ULP)-F was observed monitoring R3's blood glucose (blood sugar in the blood) level. R3's service plans lacked the following required content: -the identification of staff or categories of staff who would provide the services for blood glucose monitoring; and -the method of monitoring staff providing services. R5 R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management, laundry, and housekeeping.	01650		

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01650	Continued From page 77 On October 18, 2022, at 2:32 p.m., ULP-F was observed administering R5 scheduled afternoon medications. R5's service plan lacked the following required content: -the method of monitoring staff providing services. On October 21, 2022, at 1:19 p.m., director of nurses (DON)-B stated R3 and R5's service plans did not include the method for monitoring staff providing the services. Further, DON-B confirmed R3's service plan did not identify staff who would provide blood glucose monitoring. R6 R6's service plan dated July 11, 2022, indicated R6 received the following services: medication administration, morning and evening cares, and laundry. On October 18, 2022, at approximately 9:10 a.m., the surveyor observed ULP-E administer R6's morning medications. R6's service plan lacked the following required content: -the method of monitoring staff providing services. R7 R7's service plan dated September 7, 2022, indicated R7 received the following services: medication administration, assistance with CPAP (continuous positive airway pressure) machine, compression stockings, laundry and housekeeping. On October 18, 2022, at approximately 8:10 a.m.,	01650		

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01650	Continued From page 78 the surveyor observed ULP-E administer R7's morning medications. R7's service plan lacked the following required content: -the identification of staff or categories of staff who would provide the services for assistance with CPAP machine; and -the method of monitoring staff providing services. On October 21, 2022, at 1:45 p.m. DON-B confirmed R6 and R7's services plans lacked the required content as indicated above. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans will include: - an identification of staff or categories of staff who will be providing services; and - a schedule and method for the next planned monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	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	01700		

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01700	Continued From page 79	01700		

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:
Based on interview and record review the licensee failed to ensure medication administration assessments were conducted face-to-face with the resident for four of four residents (R3, R5, R6, R7).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

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01700	Continued From page 80 R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received assistance with medication administration. On October 17, 2022, at 12:02 p.m., unlicensed personnel (ULP)-F was observed administering R3's Lantus insulin. R3's medication assessment dated September 17, 2022, was completed remotely by (registered nurse) RN-C. R5 R5's diagnoses included atrial fibrillation (irregular heartbeat). R5's service plan dated June 29, 2022, indicated R5 received assistance with medication administration. On October 18, 2022, at 2:32 p.m., ULP-F was observed administering R5 scheduled afternoon medications. R5's medication assessment dated June 22, 2022, was completed remotely by RN-C. R6 R6's service plan dated July 11, 2022, indicated R6 received assistance with medication administration. On October 18, 2022, at approximately 9:10 a.m., the surveyor observed ULP-E administered R6's morning medications.	01700		

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01700	Continued From page 81 R6's medication management assessment dated July 28, 2022, was completed remotely by RN-C. R7 R7's service plan dated September 7, 2022, indicated R7 received assistance with medication administration. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications. R7's medication management assessments dated June 9, 2022, and September 7, 2022, were completed remotely by RN-C. On October 21, 2022, at 1:45 p.m., director of nursing (DON)-B confirmed R3, R5, R6 and R7's medication management assessments were not completed face-to-face by a RN. DON-B stated all resident assessments were completed remotely by RN-C. The licensee's 7.01 Medication Management - Assessment, monitoring, and Reassessment policy dated August 1, 2022, indicated the assessment must be conducted face-to-face with the resident by an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 82 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, one of two unlicensed personnel (ULP-E) demonstrated competency for administering medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: This resulted in an immediate order on October 20, 2022, at 11:37 a.m. ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's training record lacked evidence ULP-E had been trained and	01750		

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01750	Continued From page 83 demonstrated competency in medication administration. On October 18, 2022, at approximately 7:29 a.m., the surveyor observed ULP-E to prepare R10's morning medications and administer to R10. Medications prepare by ULP-E included: -levothyroxine 75 mcg (micrograms) one table every morning; -oyster shell calcium 500 mg (milligrams); -Propranolol 40 mg; -Quinapril 5 mg; -sertraline 50 mg; -spironolactone 25 mg; -vitamin D3 one tablet; -erythromycin ointment to right eye; -Lantus 20 units; and -Novolog 21 units. On October 18, 2022, at approximately 7:30 a.m., the surveyor observed ULP-E apply gloves, dial the Lantus pen to 20 units and administer the Lantus insulin to R10 without first priming the Lantus pen. ULP-E confirmed she did not prime the Lantus pen and that she had been told to prime the pen. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E prepare R7's morning medications and left the medication cup on the table next to where R7 was sitting eating her breakfast in her room. The following medications were left on the table in the resident's apartment: -levothyroxine 150 mcg, instructions indicated the medication was to be administered one-half hour to one hour before breakfast; -tramadol 25 mg; -torsemide 20 mg; -Eliquis 5 mg,	01750		

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01750	Continued From page 84 -spironolactone 25 mg, -calcium 600 mg; -cetirizine HCL 5 mg; -escitalopram 20 mg; -famotidine 20 mg; and -potassium chloride ER 20 mEq (milliequivalent's). R7's Medication Assessment dated September 7, 2022, indicated R7 is too forgetful and anxious to administer her own medications. On October 20, 2022, at approximately 9:00 a.m., director of nurses (DON)-B stated have not been able to do the training. They have been bringing people in to work and putting them on the floor with experienced ULP. On October 20, 2022, at approximately 11:15 a.m., business office manager (BOM)-M confirmed ULP-H's training record lacked documentation pertaining to training and competency of medication administration. BOM-M stated they were aware there was no documentation of medication training in ULP-H's record for the past two months. The licensee's Medication and Treatment Administration and Delegation Policy dated August 1, 2021, indicated when administration of medications and treatment/therapy is delegated or assigned to unlicensed personnel (ULP), the licensee would ensure that the registered nurse has: -Instructed the ULP in the proper methods with the respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures.	01750		

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01750	Continued From page 85 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor on October 21, 2022, however, non-compliance remains at a scope and level of three, isolated (G). TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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 observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 86 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 entrance conference on October 28, 2022, at 9:52 a.m., director of nursing (DON)-B confirmed the licensee's medication administration times were a.m. (morning) and p.m., (evenings), unless otherwise ordered. R5's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), depression, coronary artery disease (blockage or narrowing of the heart vessels). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management services. R5's prescriber orders dated March 23, 2022, indicated atorvastatin (medication to treat high cholesterol) 80 milligrams one tablet, and metoprolol (used to treat high blood pressure) 50 mg were to be given at bedtime. R5's October 2022, Medication Administration Record (MAR) indicated atorvastatin 80 mg one tablet was to be administered by mouth daily at bedtime, and metoprolol extended release 50 mg to take one and one-half tablets twice daily, at a.m., and p.m. On October 18, 2022, at 2:32 p.m., the surveyor observed unlicensed personnel (ULP)-F	01760		

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01760	Continued From page 87 administer R5's following medications: -atorvastatin 80 mg one tablet -metoprolol 50 mg one and one-half tablets; -Eliquis 5 mg tablet; -pantoprazole 40 mg tablet; and -tamsulosin 0.4 mg tablet. On October 19, 2022, at 10:41 a.m., ULP-F confirmed medication administration times were scheduled for a.m., between 5:30 a.m. to 1:30 p.m., and p.m., between 1:30 p.m. to 10:00 p.m., unless otherwise directed on the MAR. ULP-F confirmed she administers R5's atorvastatin and metoprolol in the afternoon anytime between 1:30 p.m., and 10:00 p.m. ULP-F confirmed R5's atorvastatin order directed atorvastatin was to be administered at bedtime and R5's MAR did not indicate R5's metoprolol was to be given at bedtime. On October 21, 2022, at 1:19 p.m., DON-B confirmed R5's atorvastatin and metoprolol were ordered to be administered at bedtime and should be giving as directed. DON-B stated medications administration times needed to be more specific times on the MAR's instead of a.m., and p.m., to ensure mediations were given as prescribed and to avoid medication errors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 88	01790		

nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of

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01790	Continued From page 89 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-E, ULP-F) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all seventy (70) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 17,	01790		

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01790	Continued From page 90 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-A and director of nurses (DON)-B confirmed the licensee provided medication management services to 70 residents at the facility, and the ULP would prepare and send medications with the residents for unplanned times away. ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 18, 2022, at approximately 8:10 a.m., the surveyor observed ULP-E administer R7's morning medications. ULP-F ULP-F started employment on August 16, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 18, 2022, at 7:06 a.m., the surveyor observed ULP-F administer R12's morning medications. ULP-E and ULP-F's employee records lacked evidence to indicate they had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On October 20, 2022, at 11:11 a.m. business office manager (BOM)-M confirmed ULP-E and ULP-F's employee records lacked evidence they had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home.	01790		

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01790	Continued From page 91 The licensee's 7.10 Medication Management - Planned and Unplanned Time Away policy dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if, the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures. 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	01880		

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01880	Continued From page 92 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: During the entrance conference on October 17, 2022, at 9:52 a.m., licensed assisted living director (LALD)-A and director of nursing (DON)-B confirmed the licensee provided medication management services to the licensee's residents including medications storage. On October 20, 2022, at 1:13 p.m., the surveyor observed the medication refrigerator with registered nurse (RN)-B. The refrigerator had two separate internal thermometers, one indicated 30 degrees Fahrenheit (F), and the second thermometer indicated 36 degrees F. DON-B stated the night shift staff were responsible for monitoring and recording daily medication refrigerator temperatures. DON-B verified the refrigerator temperature log lacked daily monitoring of temperatures and verified the following medications were being stored: -six (6) unopened Novolog (short acting insulin) pens; -eight (8) unopened Lantus SoloStar (long-acting insulin) pen; -two (2) unopened Humalog Kwikpen (fast acting insulin) pens; -two (2) unopened bottle of timolol maleate 0.5% eye drops (used to treat increased pressure in the eye); -two (2) unopened bottles of latanoprost ophthalmic 0.005% eye drops (used to treat increased pressure in the eye); and -two (2) unopened bottle of dorzolamide and timolol ophthalmic eye drop (used to treat	01880		

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01880	Continued From page 93 increased pressure in the eye). The refrigerator temperature log posted on the outside of the medication refrigerator indicated the first temperature recorded was September 12, 2020, and the last recorded temperature was August 8, and year was not documented. The manufacturer's instructions for Lantus SoloStar insulin pen revised November 2018, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog insulin pen dated April 2015, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Novolog to freeze. The manufacturer's instructions for Humalog Kwikpen insulin dated November 2019, indicated unopened insulin should be stored in a refrigerator 36-46-degrees F and not to use if had been frozen. The manufacturer's instructions for Xalantan (latanoprost ophthalmic solution) dated August 2011, indicated to store unopened bottle(s) under refrigeration between 36-46 degrees F. The manufacturer's instructions for timolol eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle. The manufacturer's instructions for Dorzolamide eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle. The licensee's Medication Storage policy dated	01880		

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01880	Continued From page 94 August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for R10, R14, R15, R16, and R17. In addition, the licensee failed to ensure medications were maintained bearing the original prescription label for R18, R19, and further, the licensee failed to monitor for expired medications for R19. 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).	01890		

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01890	Continued From page 95 The findings include: TIME SENSITIVE MEDICATIONS/ORIGINAL PRESCRIPTION LABEL On October 17, 2022, at 11:27 a.m., the surveyor observed the medication cart stationed on the third floor with unlicensed personnel (ULP)-E. ULP-E confirmed the following: -R10's opened bottle of latanoprost 0.005% ophthalmic suspension (medication to treat glaucoma) had a label which directed to discard 45 days after opening; however, lacked the date the eye drop had been opened and when the eye drop would expire. R10's two (2) opened bottles of prednisone 1% eye drops (used to decrease swelling and irritation) lacked the date they were opened or would expire. -R15's opened bottle Dorzolamide 2% and two (2) opened bottles of timolol maleate eye drops lacked the date the eye drops were opened and when the eye drops would expire. -R16's opened bottle of timolol maleate eye drop, and Alphagan eye drop (used to treat high eye pressure) lacked original prescription labels and lacked the date the eye drops had been opened and when the eye drops would expire. -R17's opened bottle of latanoprost 0.005% ophthalmic suspension had a label which directed to discard 45 days after opening; however, lacked the date the eye drop had been opened and when the eye drop would expire. On October 17, 2022, at approximately 11:49 a.m., the surveyor observed the medication cart	01890		

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01890	Continued From page 96 on the fifth floor with ULP-F. ULP-F confirmed staff were to date insulin and eye drops with an expiration date after opening and confirmed the following: -R14's opened bottle of timolol maleate eye drop lacked the date the eye drop had been opened and when the eye drop would expire. -R18's Lantus insulin pen lacked an original prescription label to include the residents name, pharmacy, instructions for use, date dispensed, and prescription number. EXPIRED MEDICATION -R19's fluticasone propionate allergy nasal spray lacked an original prescription label had an expiration date of March 11, 2022. On October 21, 2022, at 1:19 p.m., director of nursing (DON)-B confirmed time-sensitive medications such as insulin and eye drops, should be dated after opening to include the date the medications would expire. DON-B stated the licensee did not have a formal auditing schedule in place for the medications carts to ensure there were no expired medications. The manufacturer's instructions for latanoprost ophthalmic solution revised August 2011, indicated once the bottle was opened, store at room temperature for up to six weeks. The manufacturer's instructions for Alphagan eye drop dated February 2022, indicated to use within 28 days after opening, then discard bottle. The manufacturer's instructions for timolol eye drop dated January 2020, indicated to use within	01890		

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01890	Continued From page 97 28 days after opening, then discard bottle. The manufacturer's instructions for Dorzolamide eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle. The manufacturer's instructions for Lantus insulin pen dated December 2020, indicated Lantus insulin can be stored for up to 28 days at room temperature after opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	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.	01910		

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01910	Continued From page 98 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R11) upon discharge, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference, on October 28, 2022, at 9:52 a.m., director of nursing (DON)-B stated she only documented disposition of narcotics and did not document the disposition of any other medications. DON-B further stated a large number of resident medications that were no longer being used, were recently destroyed using "green buckets" that contained a powdery substance and confirmed those medications were not documented. The licensee's Discharge Resident/Client Roster list dated October 17, 2021 to October 17, 2022, indicated R11's services started May 7, 2018, and deceased on September 14, 2022. R11's diagnosed included diabetes, congestive heart failure, chronic kidney disease and long-term use of anticoagulants (medications used to thin the blood).	01910		

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01910	Continued From page 99 R11's service plan dated November 30, 2020, indicated R11 received medication management services. A request of R11's prescriber orders and medication administration record were requested and not provided. R11's record lacked documentation of R11's disposition of medications. On October 19, 2022, at 8:32 a.m., DON-B confirmed R11's record lacked documentation of disposal of R11's medications. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated the licensee 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by	01950		

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01950	Continued From page 100 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of one employees (ULP-E). In addition, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for treatments one of one residents (R3). 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	01950		

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	30434	A. BUILDING: _____ B. WING _____	10/21/2022

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01950	Continued From page 101 situation has occurred only occasionally). The findings include: ULP-E ULP-E started employment on October 3, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Blood Glucose Monitoring with Freestyle Libre R10's prescriber's orders dated August 16, 2022, included blood glucose monitoring daily using the Freestyle Libre 14-day system (continuous blood glucose monitoring system). On October 18, 2022, at 7:29 a.m., the surveyor observed ULP-E scan R10's Freestyle Libre 14-day system to obtain R10's blood glucose reading of 141. ULP-E stated she changes R10's Freestyle Libre 14-day system every 14 days. ULP-E stated there are written instructions with each new Libre system used. ULP-E's employee record lacked evidence to indicate ULP-E was trained and demonstrated competency to a RN to perform blood glucose monitoring using the Freestyle Libre 14-day system. Compression Stockings and CPAP R7's prescriber's orders dated October 4, 2022, include compression stockings on in a.m. and off in the p.m., and CPAP (continuous positive airway pressure) machine wear at night and clean weekly. On October 18, 2022, at 8:10 a.m. the surveyor observed ULP-E apply R7's compressions stockings.	01950		

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01950	Continued From page 102 R7's Service Recap Summary for September 2022, indicated ULP-E assisted R7 with R7's CPAP machine on September 2 and 23, 2022. ULP-E's employee record lacked evidence to indicate ULP-E was trained and demonstrated competency to a RN to perform application of compression stockings and assistance with CPAP machine. On October 20, 2022, at 11:11 a.m., business office manager (BOM)-M confirmed ULP-E's employee record lacked documentation pertaining to the training and competency of Libre Blood Glucose Monitoring System. compression stockings and CPAP machine. WRITTEN INSTRUCTIONS R3 R3's diagnoses included diabetes type II. R3's service plan dated July 11, 2022, indicated R3 received the following services: medication management, blood glucose monitoring, grooming, personal cares, and laundry. R3's prescriber orders dated April 22, 2022, indicated blood glucose monitoring two (2) times per day. On October 17, 2022, at 12:02 p.m., ULP-F was observed monitoring R3's blood sugar with a blood glucose meter which was used for other residents. R3's record lacked written instructions for monitoring R3's blood glucose with the use of the blood glucose meter.	01950		

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01950	Continued From page 103 On October 21, 2022, at 1:19 p.m., director of nursing (DON)-B confirmed the licensee did not have specific written treatment instructions for each resident that was documented in the resident's record. DON-B further stated, the licensee was looking into purchasing a written treatment procedure manual from Care Providers. The licensee's 5.02 Competency Training Evaluation policy dated August 1, 2021, indicated prior to the delegation of services the registered nurse must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated, August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee would ensure the registered nurse specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 104 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for one of two residents (R7). 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: R7's diagnoses included chronic atrial fibrillation. R7's service plan and master care plan dated September 7, 2022, indicated R7 required assistance with compression stockings and CPAP (continuous positive airway pressure) machine. R7's prescriber's orders dated October 4, 2022, include compression stockings on in a.m. and off in the p.m., and CPAP machine wear at night and clean weekly.	01960		

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01960	Continued From page 105 On October 18, 2022, at approximately 8:10 a.m. the surveyor observed unlicensed personnel (ULP)-E apply R7's compressions stockings. R7's Service Recap Summary for September 2022, indicated the ULP documented the services as follows: -Compression stocking off fifteen (15) out of thirty (30) opportunities; and -Assistance with CPAP machine sixteen (16) out of thirty (30) opportunities. R7's Service Recap Summary for October 2022, indicated the ULP documented the services as follows: -Assistance with CPAP machine fifteen (15) out of seventeen (17) opportunities. On October 21, 2022, at 1:45 p.m., director of nurses (DON)-B confirmed R7's treatments were not documented as indicated above. The licensee's 2.38 Resident Record-Information and Content policy dated August 1, 2021, indicated the resident's record must include documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 106 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R6). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This practice resulted in an immediate order for correction on October 18, 2022. The findings include: BED RAILS R6's diagnoses included malignant neoplasm of left breast, CVA (cerebral vascular accident), and Parkinson's disease. On October 18, 2022, at approximately 1:01 p.m., the surveyor observed one metal bed rail on R6's hospital-style bed. The device was rectangular shaped, approximately 29 inches wide and 18 inches tall, with seven (7) vertical bars. Four (4) spaces measured about three and a half (3 1/2) inches apart and four (4) spaces measured about two	02310		

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02310	Continued From page 107 and a half (2 1/2) inches apart. Measurements were confirmed with director of nurses (DON)-B. The bedrail was bolted securely to the bed frame and there was no gap between the mattress and the frame. R6's Bed Safety Assessment, completed remotely, by registered nurse (RN)-C, on July 28, 2022, Bed safety zones measured as follows: Zone one (1) - four (4) inches. R6's Master Care Plan las updated by RN-C on July 28, 2022, indicated R6 used a bed rail to aid in position in bed. Needs one person assist with transfers. R6's bed rail measurements on the Bed Safety Assessment, completed on July 28, 2022, did not match the measurements provided by DON-B on October 18, 2022. On October 18, 2022, at approximately 12:46 p.m., DON-B confirmed R6's Bed Safety Assessment was completed remotely by RN-C. DON-B was unable to indicate who did the measurements for the assessment. DON-B also stated RN-C has completed all resident assessment remotely and it has been a long time since DON-B has completed resident assessments. On October 18, 2022, at approximately 1:07 p.m., maintenance (M)-I stated he had not completed any bed rail measurements for any of the licensee's residents since he started employment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4	02310		

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02310	Continued From page 108 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's Side rails policy dated August 1, 2021, indicated when side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The licensee's staff would determine if the rail was considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with the manufacturer's directions. b. The side rails are to installed securely and maintained in good operating condition. c. The side rails design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75 inches. The policy further indicated, the licensee would	02310		

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02310	Continued From page 109 inform local know hospice providers and known medical equipment suppliers that the licensee's residents would only be permitted to use side rails that comply with the 2006 FDA dimensional guidance to reduce entrapments. No additional information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's on-site observation and review by evaluation supervisor on October 19, 2022, however, non-complaince remains at a scope and severity of level three, widespread (I). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the care and services were provided according to an up-to-date service plan, and acceptable health care and medical, or nursing standards for one of one resident, R3 with medication set-up.	02320		

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02320	Continued From page 110 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 17, 2022, at 9:52 a.m., licensed assisted living director (LALD)-A and director of nurses (DON)-B confirmed the licensee provided medication management services to include medication set up. DON-B stated her and other ULPs would set up resident medications together in medication dosage boxes (a pill box container used to organize your medications) weekly on Tuesdays. DON-B stated since she was the only in house licensed staff, she would have the ULPs assist with medication set up under her supervision. R5's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), depression, coronary artery disease (blockage or narrowing of the heart vessels). R5's service plan dated June 29, 2022, indicated R5 received the following services: medication management services to include medication set up. R5's prescriber orders dated March 23, 2022, indicated atorvastatin (medication to treat high cholesterol) 80 milligrams one tablet, and metoprolol (used to treat high blood pressure) 50 mg were to be given at bedtime.	02320		

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02320	Continued From page 111 On October 18, 2022, at 2:32 p.m., the surveyor observed unlicensed personnel (ULP)-F administer R5's following medications from medication dosage boxes: -atorvastatin 80 mg one tablet -metoprolol 50 mg one and one-half tablets; -Eliquis 5 mg tablet; -pantoprazole 40 mg tablet; and -tamsulosin 0.4 mg tablet. R5's October 2022, medication set up sheet indicated health unit coordinator (HUC)-J set up R5's mediations via medication planner from October 5-11, 2022, to later be administered by ULPs to include the following medications: -bupropion hcl 150 mg one tablet daily for depression; -Eliquis 5 mg one tablet twice a day; -metoprolol succinate 50 milligrams twice a day for atrial fibrillation; -sertraline 100 mg two tablets daily for depression; -thiamine 100 mg one tablet daily for supplementation; -atorvastatin 80 mg one tablet at bedtime for high cholesterol; -pantoprazole 40 mg one tablet daily; and -tamsulosin 0.4 mg one tablet daily for prostate. R5's October 2022, medication set up sheet indicated ULP-F set up R5's mediations via medication planner from October 12-18, 2022, to later be administered by ULPs to include the following medications: -bupropion hcl 150 mg one tablet daily for depression; -Eliquis 5 mg one tablet twice a day; -metoprolol succinate 50 milligrams twice a day for atrial fibrillation; -sertraline 100 mg two tablets daily for	02320		

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02320	Continued From page 112 depression; -thiamine 100 mg one tablet daily for supplementation; -atorvastatin 80 mg one tablet at bedtime for high cholesterol; -pantoprazole 40 mg one tablet daily; and -tamsulosin 0.4 mg one tablet daily for prostate. On October 18, 2022, at 7:12 a.m., ULP-F stated she and other ULPs assist DON-B with setting up residents' medications on Tuesdays. The licensee's 7.09 Medication Management-Dosage Box Setup dated August 1, 2022, indicated a licensed nurse at the facility would set up resident dosage boxes weekly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *10/17/22*
Time: 11:00:20
Report: 1032221166

Food and Beverage Establishment Inspection Report

Location:
St. Ann's Home
330 East 3rd Street
Duluth, MN55805
St. Louis County, 69

Establishment Info:
ID #: 0021862
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
St. Ann's Home

Phone #: 2187278831
ID #: 27343

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.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12C

MN Rule 4626.0275C Discontinue storing food preparation or dispensing utensils on equipment surfaces that are not cleaned and sanitized at least once every 4 hours.

DO NOT STORE COLESLAW SCOOP ON LID OF CONTAINER IN WALK-IN COOLER

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

FOOD BOXES ON FLOOR IN FREEZER

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

DISCARD CHIPPED AND SCRATCHED CUTTING BOARDS

Comply By: 10/25/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
WALK-IN BREAD COOLER SIDING IS CHIPPING. REPLACE WORN SIDING
Comply By: 11/18/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
ICE BUILD UP IN WALK-IN FREEZER. REPAIR UNIT TO PREVENT ICE BUILD UP
Comply By: 11/22/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.
HANG MOP BY DISHWASHER AREA
Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = at 400PPM Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Quaternary Ammonia: = at 400PPM Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: CHICKEN NUGGET
Violation Issued: No

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: WILD RICE SOUP
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: AMERICAN CHEESE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: HARD BOILED EGG
Violation Issued: No

Process/Item: Walk-In Cooler 2
Temperature: 39 Degrees Fahrenheit - Location: TOMATO
Violation Issued: No

Process/Item: Walk-In Cooler 2
Temperature: 37 Degrees Fahrenheit - Location: PICKLE
Violation Issued: No

Process/Item: Walk-in Cooler 3
Temperature: 34 Degrees Fahrenheit - Location: HOTDISH
Violation Issued: No

Process/Item: Walk-in Cooler 3
Temperature: 33 Degrees Fahrenheit - Location: CORN
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

Process/Item: Walk-in Cooler 4
Temperature: 37 Degrees Fahrenheit - Location: BUTTER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	6

Report reviewed with MANAGER BRYNN. Potential hazards in day-to-day operation were discussed, including employee illness, excluding/restricting employees experiencing illness symptoms, recording employee illness symptoms,

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MDH inspection report number 1032221166 of 10/17/22.

Certified Food Protection Manager: BRYNN L ERICKSON

Certification Number: FM71189 Expires: 10/12/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

BRYNN L ERICKSON
KITCHEN MANAGER

Signed: _____

Ben Kubes
Environmental Health Specialist
Duluth
ben.kubes@state.mn.us

Report #: 1032221166

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	0	Date	10/17/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:20
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
St. Ann's Home	330 East 3rd Street	Duluth, MN	55805	2187278831

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0021862	St. Ann's Home	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 (IN) OUT	PIC knowledgeable; duties & oversight		
2 (IN) OUT N/A	Certified food protection manager, duties		
Employee Health			
3 (IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 (IN) OUT	Proper use of reporting, restriction & exclusion		
5 (IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 (IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 (IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 (IN) OUT N/O	Hands clean & properly washed		
9 (IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 (IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 (IN) OUT	Food obtained from approved source		
12 IN OUT N/A (N/O)	Food received at proper temperature		
13 (IN) OUT	Food in good condition, safe, & unadulterated		
14 IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 (IN) OUT N/A N/O	Food separated and protected		
16 (IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17 (IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 (IN) OUT N/A N/O	Proper cooking time & temperature		
19 (IN) OUT N/A N/O	Proper reheating procedures for hot holding		
20 (IN) OUT N/A N/O	Proper cooling time & temperature		
21 (IN) OUT N/A N/O	Proper hot holding temperatures		
22 (IN) OUT N/A	Proper cold holding temperatures		
23 (IN) OUT N/A N/O	Proper date marking & disposition		
24 IN OUT (N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 (IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT (N/A)	Food additives: approved & properly used		
28 (IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	(IN) OUT N/A N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display	X	
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43	X	In-use utensils: properly stored	X	
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/18/22

Inspector (Signature) BG