Electronically Delivered

January 16, 2024

Licensee
Victor's Place
103 East Niagara Street
Duluth, MN 55811

RE: Project Number(s) SL35548015

Dear Licensee:

On January 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 18, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered
November 1, 2023

Licensee
Victor's Place
103 East Niagara Street
Duluth, MN 55811

RE: Project Number(s) SL35548015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax:1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35548	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTOR'S PLACE	103 EAST NIAGARA STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36746015 On October 16, 2023, through October 18, 2023, 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 3 active residents receiving services under the Assisted Living license. An immediate correction order was identified on October 17, 2023, issued for SL35548015-0, tag identification 0820. The immediate correction order(s) tag identification 0820, identified on October 17, 2023 has had the immediacy lifted as of October 17, 2023.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (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 and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 16, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services	0 490		

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0 490	Continued From page 2 appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 3 residents 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 16, 2023, at 9:48 a.m., owner (O)-A and clinical nurse	0 490		

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0 490	Continued From page 3 supervisor (CNS)-B stated they used to schedule daily activities for the residents but the residents showed very little interest in participating. O-A stated the residents were independent, some had jobs, and directed their own social activities. O-A stated the licensee provided one on one time with each resident once a month, took the residents shopping for personal needs every week, and went on a variety of outings. During the facility tour on October 16, 2023, at 10:45 a.m., the evaluator observed a calendar hanging on the kitchen wall with random days of a events written on the calendar. On October 18, 2023, at 10:30 a.m., the surveyor reviewed the licensee's activities calendar which indicated the following: -In August 2023, there were five (5) out 31 days of events written on the calendar; -In September 2023, there were six (6) out of 30 days of events written on the calendar; and -In October 2023, there were five (5) out of 31 days of events written on the calendar. On October 18, 2023, at 11:00 a.m., licensed assisted living director (LALD)-C stated she was unaware the licensee was required to have at least one social or recreational activity scheduled daily. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 4 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained a current annual performance review for one of one employee (unlicensed personnel (ULP)-D). 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	0 650		

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0 650	Continued From page 5 situation has occurred only occasionally). The findings include: ULP-D had a start date of March 23, 2020, to provide direct care under the assisted living license. On October 16, 2023, at 2:13 p.m., the surveyor observed ULP-D administering R1's scheduled afternoon medications. ULP-D's employee record included a previous performance evaluation conducted on January 27, 2021. ULP-D's employee record did not include an annual performance evaluation for 2022 or 2023. On October 16, 2023, at 3:07 p.m., licensed assisted living director (LALD)-C stated ULP-D did not have an annual performance evaluation completed for the year of 2022 or 2023. The licensee's Performance Evaluation policy dated November 7, 2022, indicated a formal performance evaluation would be conducted for all staff providing home care services at least annually and would address areas of improvement needed and any additional education or training needs for the staff member. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 6 (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 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. 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	0 680		

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0 680	Continued From page 7 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: The licensee's Emergency Preparedness Manual dated November 7, 2022, included a Hazard Vulnerability Risk Assessment dated April 20, 2022. The EPP binder included an organizational chart for the facility, generic instructions for staff to follow in case of a fire, severe weather, power outage, hazardous materials, evacuation, and emergency lockdown. The licensee's EPP did not include the following: -a quarterly review of the missing resident policy, last reviewed November 7, 2022; -a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; -process for EP cooperation with state and local EP officials/organizations; -development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - shelter in place; - emergency staffing strategies to include volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - arrangement with other facilities; -a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for local EP staff, state	0 680		

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0 680	Continued From page 8 licensing and certification agencies; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; -a method of sharing information from the EPP with residents and their families; -an emergency prep testing requirements to include: -participation in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise; and -an additional annual exercise that may include a second full-scale exercise or mock disaster drill or table-top exercise and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On October 17, 2023, at 4:01 p.m., licensed assisted living director (LALD)-C stated she was responsible for developing and maintain the licensee's EPP and stated she was not aware of all the required content for the Emergency Preparedness: Appendix Z of the State Operations Manual (SOM). The licensee's Emergency Preparedness policy dated November 7, 2022, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The EPP would be reviewed/updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 780	Continued From page 9	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in the resident rooms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 10 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 16, 2023, at approximately 11:30 a.m. with owner maintenance (O)-A and clinical nurse supervisor (CNS)-B it was also observed the smoke alarms were not interconnected in resident rooms #1 and #2 so that activation of any one smoke alarm activates all alarms throughout the facility. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. This deficient finding was visually verified by O-A and CNS-B at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 11 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and 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 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). Findings include: On a facility tour on October 16, 2023, at approximately 11:30 a.m. with owner (O)-A and clinical nurse supervisor (CNS)-B it was observed that fire extinguishers were installed but not maintained as required. Fire extinguishers are required to be inspected monthly and serviced by a certified technician annually. A documentation tag is required to be kept with the extinguisher indicating monthly and annual inspections and service. O-A and CNS-B visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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	35548	A. BUILDING: _____ B. WING _____	10/18/2023

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0 810	Continued From page 12	0 810		
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. (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:	0 810		

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0 810	Continued From page 13 Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all 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 potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on October 18, 2023, at approximately 10:30 a.m. of documents provided by licensed assisted living director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents in the event of a fire or similar emergency for this specific facility. Record review of the available documentation indicated that employees have not received training on the fire safety and evacuation plan for this facility. Training of employees is required at hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures of this facility. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills.	0 810		

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0 810	Continued From page 14 Record review of the available documentation indicated that the facility did not offer specific training based on the facility fire safety and evacuation plan to the residents. Resident training based on the facility fire safety and evacuation plan is required to be offered to the residents at least annually. Record review of the available documentation indicated that evacuation drills have not been conducted at the facility. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from employee training. All deficiencies were verified by LALD-C during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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0 820	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). Findings include: On a facility tour on October 17, 2023, at approximately 1:15 p.m. with clinical nurse supervisor (CNS)-B and owner (O)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms #1, #2, #3 and #4. Occupied Resident Rooms Resident sleeping room #1 and #2 emergency escape and rescue clear window opening measurements are 29 inches wide, 23 1/2 inches in height and 682 square inches in openable area. The windowsill from the floor to the clear opening measures 55 inches which exceeds the required maximum of 48 inches. The window was measured with CNS-B, O-A and survey staff present. The windows do not meet the maximum clear opening sill height of 48 inches from the floor to the clear opening.	0 820	This immediate correction order identified on October 17, 2023, has had the immediacy lifted as of October 17, 2023, by removing the resident from the room with the non-compliant window and using beds to mitigate the window sill height issue. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 16 Resident sleeping room #4 emergency escape and rescue clear window opening measurements are 16 inches wide, 48 ½ inches in height and 776 square inches in openable area. The window was measured with CNS-B and O-A and survey staff present. The window did not meet the minimum requirements for clear opening width. Unoccupied Room Resident sleeping room #3 emergency escape and rescue clear window opening measurements are 29 inches wide, 23 1/2 inches in height and 682 square inches in openable area. The windowsill from the floor to the clear opening measures 55 inches which exceeds the required maximum of 48 inches. The window was measured with CNS-B, O-A and survey staff present. The window does not meet the maximum clear opening sill height of 48 inches from the floor to the clear opening. It was explained to CNS-B and O-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. These deficient conditions were visually verified by CNS-B and O-A accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above	0 820		

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0 820	Continued From page 17 findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and clearance was received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-D). 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	01290		

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01290	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a start date of March 23, 2022, to provide direct care services to the licensee's residents. On October 16, 2023, at 2:13 p.m., the surveyor observed ULP-D administering R1's scheduled afternoon medications. ULP-D's employee record contained a background study clearance, affiliated with another assisted living license owned by the licensee, dated August 17, 2023. On October 16, 2023, at 3:10 p.m., clinical nurse supervisor (CNS)-B reviewed ULP-D's background study clearance and stated ULP-D's background study clearance was affiliated with the licensee's other assisted living owned by the licensee. The licensee's Recruitment and Hiring policy dated November 7, 2022, indicated a criminal background check would be submitted to Minnesota Department of Human Services (DHS) using NetStudy 2.0 or current version. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) day	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470		

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01470	Continued From page 19 (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 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:	01470		

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01470	Continued From page 20 (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 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 observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (unlicensed personnel (ULP)-D). 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 included: ULP-D had a start date of March 23, 2020, to provide direct care services to the licensee's residents. On October 16, 2023, at 2:13 p.m., the surveyor	01470		

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01470	Continued From page 21 observed ULP-D administering R1's scheduled afternoon medications. ULP-D's employee record lacked evidence of completing the following assisted living orientation 144G requirement topic before providing assisted living services to the licensee's residents: - an overview of the 144G statutes. On October 16, 2023, at 3:10 p.m., clinical nurse supervisor (CNS)-B reviewed ULP-D's employee record and stated she could not find evidence ULP-D completed the required training on assisted living 144 G statues, only training for home care statues. The licensee's Staff Orientation and Education policy dated November 7, 2022, indicated upon hire and before providing services to clients, all employee would complete an overview of Minnesota Home Care Statutes Sections 144A.43 to 144A.4798. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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VICTOR'S PLACE	103 EAST NIAGARA STREET DULUTH, MN 55811

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01500	Continued From page 22 (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 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,	01500		

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01500	Continued From page 23 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 observation, interview, and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). 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-D had a start date of March 23, 2020, to provide direct care services to the licensee's residents. On October 16, 2023, at 2:13 p.m., the surveyor observed ULP-D administering R1's scheduled afternoon medications. ULP-D's employee record lacked evidence ULP-D completed the following required annual training to include:	01500		

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01500	Continued From page 24 -a review of assisted living bill of rights; -a review of provider's policies and procedures; and -tuberculosis training. On October 16, 2023, at 3:10 p.m., clinical nurse supervisor (CNS)-B reviewed ULP-D's employee record and stated she could not find evidence ULP-D completed all of the required annual training noted above. CNS-B stated she was in the process of reviewing all employee records to ensure all staff have are up to date with training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 25 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services were implemented as indicated on the services plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder, autism, depression, hypertension (HTN), hyperlipidemia (high cholesterol), and hyperglycemia (low blood sugar). R1's Service Plan dated March 30, 2023, indicated R1 received treatment services and staff were to encourage and cue R1 to wear his CPAP (continuous positive airway pressure machine used to treat sleep apnea) at bedtime and during naps and cue R1 to clean CPAP daily following use. R1's Treatment Plan dated April 30, 2023, indicated R1 did not receive any treatments.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35548	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTOR'S PLACE	103 EAST NIAGARA STREET DULUTH, MN 55811

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01640	Continued From page 26 R1's Physician Visit/Order Form dated September 7, 2022, indicated R1 was seen for a CPAP follow up visit, had severe obstructive sleep apnea, was ordered to use the CPAP machine four hours a night, 70% of the time. R1's Home Health Aide Care Plan dated October 5, 2023, directed staff to encourage and cue R1 to wear his CPAP at bedtime and during naps and cue R1 to clean the CPAP daily following use. R1's Annual assessment dated January 10, 2023, did not include the use of R1's CPAP machine. R1's 90-day assessment dated March 5, 2023, indicated R1 refused the CPAP machine. R1's Progress Notes dated February 27, 2023, to August 8, 2023, did not indicate R1 was offered or refused to use his CPAP machine. R1's Home Health Aide Charting Sheet dated October 16-22, 2023, did not direct staff to encourage R1 to use his CPAP machine. On October 17, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated R1 used to wear his CPAP regularly, and for some reason started to refuse to use it. CNS-B verified R1's current service plan and care plan indicated staff were to encourage R1 to use the CPAP machine. CNS-B stated she could not find documentation in R1's record staff were encouraging R1 to use his CPAP machine or R1 was refusing. The licensee's Service Plan policy dated November 7, 2022, indicated the licensee would implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 27 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R2) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

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01910	Continued From page 28 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted September 7, 2021, and discharged on May 1, 2023. R2's May 2023, Medication Administration Record (MAR) indicated R2 received the following scheduled medications: -amlodipine (treats high blood pressure) 5 milligrams (mg) one tablet daily; -aspirin 81 mg one tablet daily with food; -calcium (supplements) 600 mg one tablet twice daily; -daily-vite (supplement) one tablet daily; -Flomax (treats enlarged prostate) 0.4 mg one capsule daily; -Florastor (probiotic) 250 mg one capsule twice daily; -folic acid (treats folic acid deficiency) 1 mg one tablet daily; -lisinopril (treats high blood pressure) 10 mg one tablet twice a day; -magnesium (supplement) 500 mg one tablet daily with a meal; -Omeprazole (treats acid reflux) 20 mg one capsule daily; -potassium chloride (supplement) 20 mEq one tablet twice daily with food; -requloid powered (fiber powder) 28.3% daily two hours after medication; and -sertraline (treats depression) 100 mg one tablet daily.	01910		

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01910	Continued From page 29 R2's prescriber orders dated January 9, 2023, included the above noted scheduled medications. R2's Discharge Summary dated April 27, 2023, indicated R2 received medication management services and was discharged to home on May 1, 2023. R2's Discharge Dispense Authorization form included a list of R2's medications noted above, were dispensed to the resident/responsible party on May 1, 2023. R2's Discharge Dispense Authorization form lacked the required content to include the medications prescriptions numbers. On October 16, 2023, at 1:49 p.m., clinical nurse supervisor (CNS)-B stated she was unaware medication prescription numbers were required when documenting the disposition of medications. The licensee's Disposition/Disposal of Medications policy dated November 7, 2022, indicated upon disposition, the license would document the following information in the clinical record to include the medication's name, strength, prescription number of medication, as applicable, quantity, date of disposition, and names/signatures of staff involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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VICTOR'S PLACE	103 EAST NIAGARA STREET DULUTH, MN 55811

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01940	Continued From page 30 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content, and further failed to ensure unlicensed personnel followed the treatment plan for one of one resident (R1) who had treatments indicated on R1's service plan and care plan.	01940		

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01940	Continued From page 31 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: On October 16, 2023, at 9:48 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee had one resident who received reminders/cues from staff to use his CPAP machine (continuous positive airway pressure used to treat sleep apnea); however, would resident would refuse to use it. R1's diagnoses included schizoaffective disorder, autism, depression, hypertension (HTN), hyperlipidemia (high cholesterol), and hyperglycemia (low blood sugar). R1's Physician Visit/Order Form dated September 7, 2022, indicated R1 was seen for a CPAP follow up visit, had severe obstructive sleep apnea was ordered to use the CPAP machine four hours a night, 70% of the time. R1's 90-day assessment dated March 5, 2023, indicated R1 refuses the CPAP machine. R1's Service Plan dated March 30, 2023, indicated staff were to encourage and cue R1 to wear his CPAP at bedtime and during naps and cue R1 to clean CPAP daily following use.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 32 R1's Treatment Plan dated April 30, 2023, indicated R1 did not receive any treatments. R1's October 2023, Medication Administration Record (MAR) did not include R1's CPAP machine. R1's Home Health Aide Care Plan updated October 5, 2023, indicated staff were to encourage and cue R1 to wear his CPAP at bedtime and during naps and cue R1 to clean CPAP daily following use. R1's Progress Notes dated February 27, 2023, to August 8, 2023, did not indicate R1 was offered or refused to use CPAP machine. R1's Home Health Aide Charting Sheet dated October 16-22, 2023, did not include staff to encourage R1 to use his CPAP machine. R1's record lacked written instructions for the use and cleaning of R1's CPAP machine. On October 17, 2023, at 9:40 a.m., CNS-B reviewed R1's medical record and stated R1 used to wear his CPAP machine daily and then started to refuse to use it. CNS-B confirmed R1's service plan and HHA plan indicate staff were to encourage R1 to wear his CPAP during naps and at night. CNS-B stated she did not see documentation on R1's MAR or HHA Documentation Sheet where it directed staff to encourage R1 to wear his CPAP machine during naps or at bedtime or written instructions of use and cleaning. CNS-B stated there was no evidence in R1's progress notes or HHA documentation staff offered or R1 refused to use the CPAP machine. CNS-B further stated she did not consider CPAP machines as treatments and	01940		

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01940	Continued From page 33 that was why it was not identified on R1's treatment plan. On October 17, 2023, at 1:15 p.m., CNS-B and the surveyor did not observe R1's CPAP machine in R1's room. CNS-B stated she did not know where R1's CPAP machine was and would further look into it. The licensee's Treatment and Therapy Management policy dated November 7, 2022, indicated the registered nurse or licensed health professional is responsible for assessing and devolving the treatment and/or therapy service plan for residents. The RN would obtain orders for all treatments and therapies and instruct other team members and provide on-gong teaching based on the written resident education instructions prepared by the RN or licensed professional. The RN or licensed professional would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addressed: -type of service to be provided; -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed personnel; and -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record. The licensee's Verbal Reminders for Medications,	01940		

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01940	Continued From page 34 Treatments and Exercises policy dated November 7, 2022, indicted Home Health Aides would document in the clinical record the provision of verbal reminders to resident for medications, treatments, and exercises. Minnesota Chapter 144G.08, Subd. 71. Treatment or therapy, defines "Treatment" or "therapy" to mean the provision of care, other than medications, ordered or prescribed by a licensed health professional and provided to a resident to cure, rehabilitate, or ease symptoms. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *10/16/23*
Time: 11:00:00
Report: 1016231138

Food and Beverage Establishment Inspection Report

Location:

Victor'S Place
103 East Niagara Street
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038625
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183487700
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

CHLORINE CONCENTRATION IN SPRAY BOTTLE WAS OVER 200 PPM. USE TEST STRIPS TO MIX CHLORINE USED ON FOOD CONTACT SURFACES BETWEEN 50-200 PPM.

Comply By: 10/16/23

Surface and Equipment Sanitizers

Chlorine: > 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: STRAWBERRIES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: TURKEY
Violation Issued: No

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

Type: Full
Date: *10/16/23*
Time: 11:00:00
Report: 1016231138
Victor'S Place

Food and Beverage Establishment Inspection Report

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

COMMENTS:

FACILITY HAS 3 RESIDENTS.

FOOD IS PREPARED FOR SOMEDAY CONSUMPTION.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016231138 of 10/16/23.

Certified Food Protection Manager ELIZABETH E. CHRISTIE

Certification Number: FM11230 Expires: 08/17/25

Signed: _____

ELIZABTH E. CHRSTIE
OWNER

Signed: _____

Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us