Electronically Delivered

January 2, 2024

Licensee
Anne's Place LLC
1137 Brainerd Avenue
Duluth, MN 55811

RE: Project Number(s) SL34248015

Dear Licensee:

On December 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 3, 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
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 11, 2023

Licensee
Anne's Place LLC
1137 Brainerd Avenue
Duluth, MN 55811

RE: Project Number(s) SL34248015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 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, 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
	34248	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE'S PLACE LLC	1137 BRAINERD AVENUE 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: SL34248015 On October 2, 2023, through October 3, 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 three active residents; all whom were receiving services under the Assisted Living license. An immediate correction order was identified on October 2, 2023, at 4:13 p.m., issued for SL34248015, tag identification 0820. On October 2, 2023, at 6:06 p.m., immediacy of correction order 0820 was removed as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of I.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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 observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required. This had the potential to 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	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license. The facility was licensed for a capacity of three and had a current census of three residents. During the entrance conference on October 2, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)-C and owner (O)-A stated the usual staffing schedule for the facility was as follows: - CNS-C was on site Monday through Friday from 9:00 a.m., until 3:00 p.m. - the facility was staffed with one unlicensed personnel (ULP) 24/7 The surveyor observed in the locked nursing office a whiteboard propped up on a table with the names of the staff working each shift for the current day. CNS-C and O-A stated this was the only place the schedule was posted and the nursing office door was always locked. CNS-C stated the staff schedule was not prominently posted for residents and visitors to access. The licensee's Staffing policy dated November 7, 2022, noted the daily staffing scheduled would be posted at the beginning of the shift in a central location accessible to staff, residents, volunteers and the public. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0180, Subp. 4. B. The daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or	0 470		

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0 470	Continued From page 3 campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. 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: (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 included document titled, Food and Beverage Establishment Inspection Report dated October 3, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 4 (21) days	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) 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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all 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	0 485		

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0 485	Continued From page 5 or has potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, at 12:09 p.m., during a tour of the facility with clinical nurse supervisor (CNS)-C, the surveyor did not observe a weekly menu posted. The surveyor observed posted on the front of the kitchen refrigerator a handwritten "Weekly Meal Plan" for the week of October 2, 2023. The menu listed for "Monday" was chicken breast, potatoes, vegetable, fruit, juice, and milk. The rest of the weekly menu was blank. On October 2, 2023, at 12:10 p.m., CNS-C stated the kitchen staff who develops the menu and does the grocery shopping was not in today. CNS-C stated the weekly menu was not posted as required and was incomplete as it only included the menu for the evening meal. The licensee's Food Service policy dated November 7, 2022, noted menus would be prepared one (1) week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
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	0 680		

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0 680	Continued From page 6 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 observation, interview, and record review, the licensee failed to develop and post 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).	0 680		

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0 680	Continued From page 7 The findings include: On October 2, 2023, at 12:46 p.m., the surveyor completed the facility tour with clinical nurse supervisor (CNS)-C. The surveyor did not observed signage posted or information regarding the licensee's EPP in the common areas of the facility. CNS-C stated the EPP was in a binder in a locked cabinet in the locked office area. CNS-C stated she was unaware the EPP should be prominently posted. The licensee's EPP dated November 7, 2022, included a Hazard Vulnerability Assessment (HVA) dated March 26, 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; - a description of the population served by the licensee; - 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; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated;	0 680		

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0 680	Continued From page 8 - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state 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; and - a method of sharing information from the EPP with residents and their families. On October 3, 2023, at 2:51 p.m., licensed assisted living director (LALD)-B stated he was aware the EPP was a work in progress. LALD-B stated he recently attended a regional meeting with the emergency preparedness coalition and has reviewed the information in Appendix Z. The licensee's Emergency Preparedness policy dated November 7, 2023, noted the facility will 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 Emergency Disaster Plan will be prominently posted on each floor of the facility. The EPP will be reviewed/updated at least annually.	0 680		

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0 680	Continued From page 9 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 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	0 810		

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0 810	Continued From page 10 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 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).	0 810		

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	34248	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE'S PLACE LLC	1137 BRAINERD AVENUE DULUTH, MN 55811

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0 810	Continued From page 11 Findings include: A record review of available documentation and phone interview were conducted on October 3, 2023, at approximately 9:15 a.m. of documents provided by licensed assisted living director (LALD)-B 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 for this specific facility in the event of a fire or similar emergency. Record review of the available documentation indicated that employees received training on general fire safety and evacuation and not specifically on the 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. 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 offered to the residents at least annually. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence. Documentation for 5 fire drills was provided in January 2023, March 2023, May 2023, July 2023	0 810		

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0 810	Continued From page 12 but did not include documentation times for what shifts were included. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from employee training records. All deficiencies were verified by LALD-B 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. 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. The licensee failed to provide resident bedrooms #1, #2 and #3 with minimum existing emergency escape and rescue window sizes meeting the minimum state standard. This	0 820	This immediate correction order identified on October 2, 2023, has had the immediacy lifted as of October 2, 2023 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 13 affected the residents in occupied bedrooms #1, #2 and #3. 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 2, 2023, at approximately 1:30 p.m. with licensed assisted living director (LALD)-B, and owner (O)-A, it was observed that emergency escape and rescue openings were not provided in resident sleeping rooms #1, #2 and #3. Resident sleeping room #1 emergency escape and rescue clear window opening measurements are 20 7/8 inches wide, 13 1/2 inches in height and 282 square inches in openable area. The window was measured with LALD-B and survey staff present. The window did not meet the minimum requirements for opening height and do not meet the minimum requirements for total openable area Resident sleeping room #2 emergency escape and rescue clear window opening measurements are 24 5/8 inches wide, 25 inches in height and 616 square inches in openable area. The window was measured with LALD-B and survey staff present. The window did not meet the minimum requirements for total openable area	0 820		

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0 820	Continued From page 14 Resident sleeping room #3 emergency escape and rescue clear window opening measurements are 14 inches wide, 21 1/8 inches in height and 295 square inches in openable area. The window was measured with LALD-B and survey staff present. The window did not meet the minimum requirements for opening width and do not meet the minimum requirements for total openable area It was explained to LALD-B that at least one 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. These deficient condition were visually verified by LALD-B accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01370 SS=D	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	01370		

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01370	Continued From page 15 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 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 was completed for one of one unlicensed personnel (ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01370		

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01370	Continued From page 16 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 16, 2022, to provide direct care services to the facility's residents. On October 3, 2023, at 12:57 p.m., the surveyor observed ULP-D administer R1's scheduled afternoon medications. ULP-D's employee record did not include documentation of training and competency for the following: - documentation requirements for all services provided - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care of hearing aides - dressing and assisting with toileting - training on the prevention of falls - standby assistance techniques and how to perform them, and - awareness of confidentiality and privacy On October 3, 2023, at 2:43 p.m., clinical nurse supervisor (CNS)-C reviewed ULP-D's employee record. CNS-C stated she could not find documentation that ULP-D had completed the above noted training and competency evaluation as required. CNS-C stated this would have occurred prior to CNS-C being hired. The licensee's Staff Competency policy dated November 7, 2022, noted training and	01370		

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01370	Continued From page 17 competency evaluations for all ULP would include the following: - Documentation requirements for all services provided - Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aides; and dressing and assisting with toileting - Standby assistance techniques and how to perform them - Awareness of confidentiality and privacy No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	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.	01380		

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01380	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 16, 2022, to provide direct care services to the facility's residents. On October 3, 2023, at 12:57 p.m., the surveyor observed ULP-D administer R1's scheduled afternoon medications. ULP-D's employee record did not include documentation of training and competency for the following: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - recognizing physical, emotional, cognitive, and developmental needs of the resident - safe transfer techniques and ambulation, and - range of motion and positioning On October 3, 2023, at 2:43 p.m., clinical nurse supervisor (CNS)-C reviewed ULP-D's employee	01380		

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01380	Continued From page 19 record. CNS-C stated she could not find documentation that ULP-D had completed the above noted training and competency evaluation as required. CNS-C stated this would have occurred prior to CNS-C being hired. The licensee's Staff Competency policy dated November 7, 2022, noted training and competency evaluations for all ULP would include the following: - Basic knowledge of body functioning and changes in body function, injuries, or other reportable changes - Recognizing physical, emotional, cognitive, and developmental needs of the resident - Safe transfer techniques and ambulation - Range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 20 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one 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 was hired on June 16, 2022, to provide direct care services to the facility's residents. On October 3, 2023, at 12:57 p.m., the surveyor observed ULP-D administer R1's scheduled afternoon medications.	01440		

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01440	Continued From page 21 ULP-D's employee record did not include documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On October 3, 2023, at 2:45 p.m., clinical nurse supervisor (CNS)-C reviewed ULP-D's employee record and stated she was unable to find where a 30-day supervision had been completed on ULP-D. CNS-C stated this would have occurred prior to CNS-C being hired. CNS-C stated she will need to do an audit of all the employee records to ensure they are complete. The licensee's Supervision: Unlicensed Staff policy dated November 7, 2022, noted direct supervision of ULP performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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	01760		

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01760	Continued From page 22 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 the steps of the medication administration process was followed for one of two employees (unlicensed personnel/ULP-D) observed administering medications. 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: Medications for R1 were documented by ULP-D as being administered prior to the medication being administered. On October 3, 2023, at 12:57 p.m., the surveyor observed ULP-d administer R1's scheduled afternoon medications. The following was observed: - ULP-D removed from the locked medication cupboard R1's medication bin and locked narcotic box - ULP-D used hand sanitizer and put on gloves - ULP-D had R1 identify herself by name and date of birth	01760		

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01760	Continued From page 23 - ULP-D removed from a blister pack R1's scheduled clonazepam (sedative) 1 milligram (mg) - ULP-D placed the medication in a medication cup - ULP-D documented in the narcotic log this medication had been removed and reconciled the count - ULP-D checked R1's medication administration record (MAR) and initialed the MAR by the medication she had checked indicating the medication had been administered - ULP- D removed from a blister pack R1's scheduled pregabalin (medication to treat nerve pain) 150 mg - ULP-D placed the medication in a medication cup - ULP-D checked R1's MAR and initialed the MAR by the medication she had checked indicating the medication had been administered - ULP-D handed the medication cup to R1 who was seated in a chair in the nursing office - ULP-D took the medications with a sip of water - R1 opened her mouth and ULP-D visualized that R1 had swallowed the medication On October 3, 2023, at 1:08 p.m., immediately following the above observation, ULP-D stated she had signed off R1's medications prior to R1 taking the medication. ULP-D stated this was not her usually practice. ULP-D stated she should have signed the medications off after R1 had taken them. On October 3, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated the staff have been instructed when administering medications to sign off the medications after the resident had taken the medication.	01760		

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01760	Continued From page 24 R1's written instructions for oral medication administration dated May 9, 2023, indicated the following: - Provide privacy - Identify client - Wash hands - Check medication profile - Check medication box - Give medication to client and watch client swallow it - Return medication to storage place and lock - Wash hands - Document on appropriate charting sheet No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 the medication refrigerator maintained an acceptable temperature. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34248	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE'S PLACE LLC	1137 BRAINERD AVENUE 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
01880	Continued From page 25 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 2, 2023, at 12:52 p.m., the surveyor reviewed the medication refrigerator in the locked nursing office with clinical nurse supervisor (CNS)-C. CNS-C stated the current temperature of the refrigerator was 42 degrees Fahrenheit (F). The refrigerator contained one unopened Victoza (anti-diabetic medication) 18 milligram/3 milliliter pen (a multiple dose pen shaped injector device) for R1. CNS-C stated the medication refrigerator temperature should be monitored daily and recorded on the paper log which was located above the medication refrigerator. The Refrigerator Temperature Logs dated September 1, 2023, through September 29, 2023, indicated the temperature of the medication refrigerator had been recorded 12 times out of the 29 opportunities. On October 2, 2023, at 12:54 p.m., the Refrigerator Temperature Logs dated September 1, 2023, through September 29, 2023, were reviewed with CNS-C. CNS-C stated the temperatures of the medication refrigerator had not been recorded daily as required. CNS-C stated staff must have just forgot to check and record the temperature. The manufacturer's instructions for Victoza pens dated June 2022, indicated prior to first use the unopened pens should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Storage/Control of Medications	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34248	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 26 policy dated November 7, 2023, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separate from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01880		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34248	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 27 record the disposition of the medications as required 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 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 on December 9, 2018, and discharged on October 12, 2022. R2's diagnoses included depression, vitamin D deficiency, hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), overactive bladder, hyperlipidemia (high cholesterol), psoriasis, and tachycardia (rapid heartbeat). R2's Medication Management Plan: Addendum to Service Plan dated May 2, 2022, indicated R2 received medication management services which included medication administration. R2's Progress Note dated October 11, 2022, noted R2 would be discharging October 12, 2022, to [name of a nearby assisted living facility]. R2's medication administration record (MAR) and future appointments were faxed to the receiving facility. R2's MAR dated October 1, 2023, through October 12, 2023, indicated R2 received the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 28 following medications: - Metamucil powder (fiber supplement) 1 tablespoon daily - lisinopril (HTN medication) 2.5 milligrams (mg) daily - oxybutynin (bladder relaxant) 5 mg ER (extended release) daily - levothyroxine (hypothyroidism) 112 micrograms (mcg) daily - vitamin D 3 2000 units daily - sertraline (antidepressant) 50 mg daily - timolol 0.5% ophthalmic solution one drop twice daily - atorvastatin (treats high cholesterol) 20 mg daily - Skyrizi (treats psoriasis) 150 mg/milliliter (ml) injected subcutaneously every 12 weeks - metoprolol (HTN medication) 12.5 ER daily R2's prescriber orders dated September 2, 2022, included all the above orders. R2's Discharge Summary dated October 12, 2022, indicated to "see MAR" for the medications at discharge. The section titled Disposition of Medications was blank. R2's record did not include a disposition of medications to include the medication 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. On October 2, 2023, at 2:56 p.m., owner (O)-A stated she did remember R2's medications were sent with her to the new facility. Clinical nurse supervisor (CNS)-C stated the previous registered nurse who completed the discharge had not documented R2's disposition of medications at the time of R2's discharge.	01910		

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01910	Continued From page 29 The licensee's Disposition and Disposal of Medications policy dated November 7, 2022, noted upon disposition, the following information would be documented in the resident's record: - Name, strength and prescription number of medications, as applicable - Quantity - Method of disposition or to whom the medications were given - Date of disposition - Name(s)/signature(s) of staff or other individuals involved in disposition - If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *10/03/23*
Time: 11:00:00
Report: 1016231136

Food and Beverage Establishment Inspection Report

Location:
Anne'S Place Llc
1137 Brainerd Avenue
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0038817
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
WILLIAM HAS SERVSAFE CERTIFICATE. OBTAIN CFPM CERTIFICATE.
Comply By: 10/27/23

Food and Equipment Temperatures

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

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

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

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

Type: Full
Date: *10/03/23*
Time: 11:00:00
Report: 1016231136
Anne'S Place Llc

Food and Beverage Establishment Inspection Report

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

COMMENTS:

ESTABLISHMENT PREPARES AND CONSUMES MEALS SAME DAY

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 1016231136 of 10/03/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
WILLIAM EGGE
DIRECTOR

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