Electronically Delivered

May 20, 2024

Licensee
The Pines
2153 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL20536015

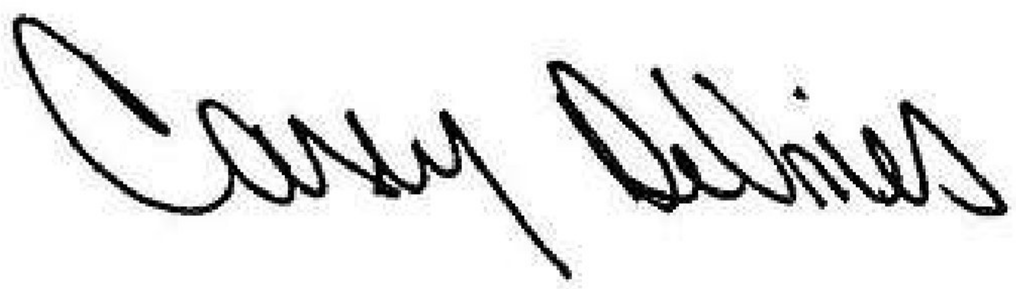
Dear Licensee:

On May 1, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 3, 2024, 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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Electronically Delivered

April 17, 2024

Licensee
The Pines
2153 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL20536015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	20536	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES	2153 7TH AVENUE NORTH ANOKA, MN 55303

(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: SL20536015-0 On April 1, 2024, through April 3, 2024, the Minnesota Department of Health conducted a full routine survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on April 2, 2024, issued for SL20536015-0, tag identification 1290. On April 2, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	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.	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 1 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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, 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 April 3, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. It was observed that the tile and grout in the main level bathroom adjacent to bedroom #1 was cracked and damaged throughout the space. There were pieces of tile missing around the toilet base and several of the floor tiles were cracked.	0 800		

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0 800	Continued From page 2 It was observed that the grout in the upstairs bathroom adjacent to bedrooms #7 and #9 was heavily stained and cracked/ damaged around the shower. The bathroom smelled damp and musty. The exhaust fan was wired to the same light switch as the vanity light which flickered and refused to turn on completely when the switch was in the "on" position. During interview on April 3, 2024, LALD-D stated they were aware of the damage in the main level bathroom and were planning to replace the tile on the floor, but they were struggling to decide when to schedule the project due to the high use of that specific bathroom by residents. LALD-D stated she understood all the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (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	0 810		

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0 810	Continued From page 3 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 3, 2024, the licensed assisted living	0 810		

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0 810	Continued From page 4 director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety/ Evacuation", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but the identification of residents who needed assistance and the level of assistance needed was documented in a "tracker packet" that was not clearly written and readily available to staff during a fire or similar emergency. During an interview on April 03, 2024, at 1:00 p.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 5 (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 (BGS) was submitted and received in affiliation with the assisted living licensee's health facility identification number (HFID) 20536 for five of 11 employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G, ULP-H). 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). The findings include:	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 6 ULP-B ULP-B was hired on January 28, 2020, to provide direct care to residents. On April 2, 2024, at 7:35 a.m., the surveyor observed ULP-B administer oral medication to R1. The licensee's Whispering Pines Assisted Living Inc. Employee Schedule for March 2024, updated March 29, 2024, indicated ULP-B worked on the following dates: -March 4-7, 9, 10, 12, 13, 18-21, 23, 24 2024. ULP-E ULP-E was hired on January 24, 2017, to provide direct care to residents. The licensee's Whispering Pines Assisted Living Inc. Employee Schedule for March 2024, updated March 29, 2024, indicated ULP-E worked on the following dates: -March 2, 3, 5, 6, 7, 8, 12, 14, 16, 17, 19, 20, 21, 22, 26, 27, 28 and 30, 2024. ULP-E's Background Study Clearance form dated January 26, 2017, indicated it was completed for HFID 20533 and ULP-E was able to provide direct contact services for the agency named. ULP-F ULP-F was hired on September 21, 2020, to provide direct care to residents. The licensee's Whispering Pines Assisted Living Inc. Employee Schedule for March 2024, updated March 29, 2024, indicated ULP-F worked on the following dates: -March 2, 3, 10, 11, 16, 17 and 31 2024.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 7 ULP-F's Background Study Notice form dated September 22, 2020, indicated it was completed for HFID 20533 and ULP-F background study was cleared. ULP-G ULP-G was hired on July 20, 2022, to provide direct care to residents. The licensee's Whispering Pines Assisted Living Inc. Employee Schedule for March 2024, updated March 29, 2024, indicated ULP-G worked on the following dates: -March 2, 10, 15, 24, 25, 2024. ULP-H ULP-H was hired on June 27, 2014, to provide direct care to residents. The licensee's Whispering Pines Assisted Living Inc. Employee Schedule for March 2024, updated March 29, 2024, indicated ULP-H worked on the following dates: -March 13, 2024. On April 1, 2024, at 2:27 p.m., the surveyor compared the licensee's NETStudy 2.0 roster (a web-based system used to submit BGS requests to the Department of Human Services (DHS)) for HFID 20536 to the licensee's employee list. The surveyor observed ULP-B, ULP-E, ULP-F, ULP-G and ULP-H were not on the roster. On April 2, 2024, at 7:35 a.m., licensed assisted living director (LALD)-D stated they did not have a BGS conducted for ULP-B, ULP-E, ULP-F, ULP-G and ULP-H under the licensee's HFID 20536. On April 2, 2024, at 10:35 a.m., the surveyor	01290		

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01290	Continued From page 8 observed LALD-D search NETStudy 2.0 to find BGS's for the above mentioned ULP's. LALD-D found a BGS for ULP-B, ULP-G and ULP-H completed under an organization affiliated HFID 20533. On April 2, 2024, at 10:45 a.m., the surveyor observed LALD-D contacted human resources (HR)-I via phone. LALD-D stated HR-I was unable to help locate ULP-E and ULP-F in NETStudy 2.0. HR-I stated they did have BGS clearance letters for both ULP's in question and would email them to LALD-D. On April 2, 2024, at 10:57 a.m., the surveyor received and reviewed the BGS clearance letters for ULP-E and ULP-F. Both BGS clearance letters were completed under HFID 20533 and indicated clearance to work and to provide direct contact services for the agency named. On April 2, 2024, at 11:15 a.m., LALD-D stated they were unable to locate further evidence of a completed BGS from NETStudy 2.0 for ULP-E or ULP-F. LALD-D was unable to demonstrate to the surveyor that ULP-E and ULP-F were affiliated to any active NETStudy 2.0 roster under the same management/ownership umbrella as the licensee's HFID. Therefore, the licensee would not have means to be notified in the event ULP-E or ULP-F were disqualified by the Department of Human Services. LALD-D stated the ULP's should have had BGS completed for the licensee's HFID 20536. The licensee's 4.02 Background Studies policy revised on September 29, 2023, indicated, "No employee may provide direct services and have independent direct contact with any resident until acceptable results of the background study have	01290		

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01290	Continued From page 9 been received. WPAL will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On April 2, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *04/01/24*
Time: 12:40:38
Report: 1051241004

Food and Beverage Establishment Inspection Report

Location:

The Pines
2153 7th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:

ID #: 0038431
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Storage Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Kitchen Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

THE FACILITY WAS INSPECTED BY TREVOR MCCLIMENT (MDH) AND KAI YANG (MDH).

MET UP WITH NURSE SURVEYOR, JOEY KEEN.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, KATE STEVENS:

VOMIT CLEAN-UP PROCEDURE
EMPLOYEE ILLNESS LOG
REPORTABLE DISEASES
HIGHLY SUSCEPTIBLE POPULATION
SELF-CLOSING BATHROOM DOORS

THE FACILITY SANITIZES KITCHENWARE WITH AN ANSI/NSF 184 COMPLIANT DISHWASHER. KITCHEN FLOOR IS CARPETED, HAS MDF WOODEN CABINETS, FAKE STONE COUNTERTOPS, AND SMOOTH CEILING TEXTURE.

Type: Full
Date: *04/01/24*
Time: 12:40:38
Report: 1051241004
The Pines

Food and Beverage Establishment Inspection Report

THERE IS AN UPRIGHT COOLER IN THE STORAGE ROOM ON THE BOTTOM FLOOR.

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 1051241004 of 04/01/24.

Certified Food Protection Manager: Nicole Aldes

Certification Number: FM107381 Expires: 06/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kate Stevens

Signed: _____

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