DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 11, 2026

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

RE: Project Number(s) SL30434016

Dear Licensee:

On January 30, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 30, 2025. 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

JMD

Electronically Delivered

November 25, 2025

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

RE: Project Number(s) SL30434016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 30, 2025, 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.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30434016-0 On October 27, 2025, through October 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 80 residents; 55 receiving services under the Assisted Living Facility license. An immediate correction was order identified on October 28, 2025, issued for SL30434016-0, tag identification 1290.	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	0 100		

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0 100	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate a therapy agency. 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, 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: During entrance conference on October 27, 2025, at 9:54 a.m. through 10:30 a.m., licensed assisted living director (LALD)-A and clinical	0 100		

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0 100	Continued From page 3 nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living requirements. CNS-B stated the licensee did not employee physical, speech or occupational therapists; however, had a therapy agency that leased office space located in the building. CNS-B stated the therapy agency provided services to residents in the assisted living and served clients in the community. LALD-A stated the therapy agency was not affiliated with the licensee and only leased office space in the building. On October 27, 2025, at 10:51 a.m. through 11:21 a.m., the surveyor toured the facility with another surveyor and maintenance director (MD)-D. The assisted living building consisted of six levels. During the facility tour, the surveyors observed an office with the name of a therapy agency located in room 115 on the first floor of the building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480		

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0 480	Continued From page 4 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 5 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 28, 2025, 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 6 (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 meet all requirements related to emergency preparedness planning (EPP), specifically related to quarterly review of the missing person policy. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 7 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: During entrance conference October 27, 2025, from 9:54 a.m. to 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B indicated the licensee was familiar with 144G statutory requirements, including the content of the EPP. The licensee's EPP was reviewed annually on March 11, 2025, however, the missing person policy indicated was last reviewed on January 17, 2025, by LALD-A, and on January 22, 2025, by CNS-B. On October 28, 2025, at 11:59 a.m., assistant administrator (AA)-G stated she maintains the EPP plan and believes the missing person policy was reviewed annually or every six months. AA-G stated she had additional EPP information to provide, which may include the quarterly review. On October 28, 2025, at 12:14 p.m., AA-G stated the normal process was to have LALD and CNS review quarterly the missing person policy, however, missed reminding LALD-A and CNS-B to review quarterly. The licensee's missing person policy, dated revised January 17, 2025, indicated the administrator and director of nursing must review quarterly. No further information was provided.	0 680		

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0 680	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect all building occupants. 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 the potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, at 10:00 a.m., the surveyor toured the facility with director of operations (DO)-D. During the tour, the surveyor observed the following: FIRE ALARM AND SPRINKLER SYSTEMS MAINTENANCE - The inspection tags on the fire sprinkler system	0 775		

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0 775	Continued From page 9 were dated July 19, 2023. Record review of the sprinkler system inspection report indicated the system was last inspected on July 19, 2023. - Record review of the fire alarm and life safety system inspection certificate indicated these systems were last inspected on August 23, 2023. During the facility tour interview, DO-D verified the inspection frequency was lacking and stated this had not been performed due to budget constraints. FIRE DOOR MAINTENANCE - In the lower level, the labeled one hour fire door was propped open with a wedge for the elevator vestibule. - In the housekeeping office on the fourth floor, the labeled 20 minute fire door was propped open with a wedge. During the facility tour interview, DO-D verified the fire door observations. Devices used to hold open fire-resistant rated doors must not prohibit the required operation and closing feature of the door to prevent the spread of smoke and fire in the event of an emergency. FIRE SAFETY SYSTEM MAINTENANCE Caps were not installed on two dry stand pipes. During the facility tour interview, DO-D verified these caps were missing. Dry stand pipe covers prevent clogging or damaging of these systems, to ensure an immediate water supply is available in an emergency. OBSTRUCTED EGRESS In the lower level, a sliding bolt lock was installed	0 775		

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0 775	Continued From page 10 on an emergency exit door. During the facility tour interview, DO-D verified the exit door observation and stated the lock was installed because there had been problems with people trespassing into the building through this door. All paths of egress must provide unobstructed exiting. CLOTHES DRYER MAINTENANCE There was an accumulation of lint behind the clothes dryers in the housekeeping laundry room on the fourth floor, creating a fire hazard. During the facility tour interview, DO-D verified the clothes dryer observations. CEILING MAINTENANCE - In the women's locker room, three ceiling tiles were not installed. - In the third floor storage room, two ceiling tiles were not installed. - In the community room, one ceiling tile was not installed. During the facility tour interview, DO-D verified the above listed ceiling observations. Ceiling tiles shall be maintained where installed to protect the integrity of fire protection systems. SMOKING MATERIAL DISPOSAL Burnt cigarettes were disposed of on the ground in the yard, in the courtyard at the front and side of the building, and in the parking lot. During the facility tour interview, DO-D verified the smoking material disposal observations. DO-D stated there were proper disposal container maintained in the designated smoking areas available for residents and employees to use.	0 775		

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0 775	Continued From page 11 ELECTRICAL - A green extension cord was used in the chapel to supply power, and extension cords were used for outdoor lights in the enclosed courtyard garden. Extension cords shall only be used for temporary power. - Weatherproof covers were missing on two electrical outlets on the exterior of the building. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage, electrical shocks, and fires. During the facility tour interview, DO-D verified the above listed electrical observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the	0 800		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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0 800	Continued From page 12 health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 29, 2025, at 10:00 a.m., the surveyor toured the facility with director of operations (DO)-D. During the tour, the surveyor observed the following: - In the mechanical room, the Reduced Pressure Zone (RPZ) inspection tag was dated March 2024, indicating the backflow preventer had not been tested in the past year. RPZ backflow preventers must be tested annually by a certified tester. - The southeast elevator (4) was out of order. - The exterior balconies were soiled from pigeons. - The cable was sagging for the camera system installed at exit door 5. During the facility tour interview, DO-D verified the above listed physical environment observations. - A ceiling light was plugged into an electrical outlet in one of the primary elevators located in the center of the building.	0 800		

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0 800	Continued From page 13 During the facility tour interview, DO-D stated the ballast in the light fixture was out of order. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01290 SS=I	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 a staff member 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 Minnesota Department of Human Services (DHS) NetStudy 2.0 background study was completed with clearance letter obtained for one of four employees (registered nurse (RN)-C). This had the potential to affect all residents of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or	01290	The licensee took appropriate action to address the immediate risk. The scope and severity remain unchanged.	

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01290	Continued From page 14 safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on October 28, 2025. The findings include: During entrance conference October 27, 2025, from 9:54 a.m. to 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B indicated the licensee was familiar with 144G statutory requirements, including the required content of an employee record. RN-C was hired on May 13, 2025, to provide direct care services to residents and supervision of staff at the facility. RN-C was licensed by the Minnesota Board of Nursing on November 18, 2013. On October 27, 2025, during an entrance conference between 9:54 a.m. and 10:30 a.m., CNS-B indicated RN-C's typical work schedule was Monday - Friday 8:00 a.m. to 4:30 p.m., and RN-C was on-call for the facility's unlicensed personnel every other week during after hours and weekends. On October 27, 2025, from 3:15 to 3:22 p.m., RN-C provided the surveyor a tour of the medication storage room and reviewed medication practices.	01290		

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01290	Continued From page 15 On October 28, 2025, at 9:45 a.m., business office manager (BOM)-E stated responsibility for maintaining employee records, including background studies, was part of BOM-E's job duties. BOM-E stated the licensee did not have a completed background study for RN-C, as RN-C was hired after 2018. BOM-E stated a webinar was presented with information about changed requirements, indicating licensed nurses working in long term care after 2018, would not require a background study. BOM-E indicated the information would be shared with the surveyor once located. On October 28, 2025, at 10:45 a.m., the surveyor reviewed with BOM-E the Minnesota Department of Health's (MDH) Background Studies for HLB (health licensing board) Licensed Providers FAQ (frequently asked questions) document, dated August 1, 2022. The document indicated the licensee did not need to complete a background study for individuals granted professional licensure after January 1, 2018. BOM-E provided the same document and stated she had a different understanding of the requirements. On October 28, 2025, at 10:49 a.m., the surveyor reviewed with CNS-B the lack of background study clearance for RN-C. CNS-B stated she recalled discussing the need for a background study with BOM-E, and perhaps BOM-E had been on vacation when RN-C was hired and it was missed. The licensee's Background Studies policy, last revised January 8, 2025, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all	01290		

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01290	Continued From page 16 employees and volunteers and contractors at [licensee's name]. No employee may provide direct services and have independent contact with any resident until acceptable result of the background study have been received. Additionally, the policy indicated if an employee was hired prior to receiving the results of the background study, or the tentative background study results indicated more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of [licensee's name] except under the direct supervision (eyesight) of another qualified person. The MDH's Background Studies for HLB-Licensed Providers FAQ document, dated August 1, 2022, indicated for question: 'How do we know if an individual has had a background study under section 214.075?' the HLBs implemented background studies under this section on January 1, 2018. They only have performed these background studies on individuals seeking initial licensure (new licensees), reinstatement after a more than-one-year lapse, or licensees applying to participate in an interstate compact. If an individual has applied for and received full licensure after January 1, 2018, completion of the 214.075 background check is implied. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

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01620	Continued From page 17 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and	01620		

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01620	Continued From page 18 cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident reassessments and monitoring not to exceed every 90 days from previous assessment for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference October 27, 2025, from 9:54 a.m. to 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B indicated the licensee was familiar with 144G statutory requirements. R4's diagnoses included Alzheimer's Disease and dementia.	01620		

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01620	Continued From page 19 R4's Service Plan-Addendum to Contract dated June 30, 2025, indicated R4 received assistance with medications, daily visits by unlicensed personnel (ULP)s and monthly vital signs; however, lacked information R4 required weekly medication set up by the nurse. On October 28, 2025, at 6:29 a.m., the surveyor observed unlicensed personnel (ULP)-I prepare R4's medication from a prefilled medication box and administer R4's medications. R4's record included a comprehensive assessment completed on May 1, 2025, and June 2, 2025. R4's record lacked evidence the RN completed ongoing 90-day assessments after the last assessment was completed June 2, 2025, (which was due by August 31, 2025). On October 20, 2025, at 9:15 a.m., CNS-B stated R4 was never added to the ongoing assessment schedule in RTasks (web-based software program) to complete required ongoing assessments. The licensee's Assessments, Reviews, and Monitoring policy dated April 10, 2024, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by registered nurse who conducted the assessments. Resident assessments and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as need based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 20 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	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, 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 observation, interview, and record review, the licensee failed to ensure the service	01640		

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01640	Continued From page 21 plan was revised to reflect current services provided for three of three residents (R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on October 27, 2025, at 9:46 a.m. through 10:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living requirements. CNS-B stated the nurses were responsible for developing and maintaining resident service plans. R4 R4's diagnoses included Alzheimer's Disease and dementia. R4's Medication Administration Summary dated October 2025, indicated R4 was scheduled and received medication administration. On October 28, 2025, at 6:29 a.m., the surveyor observed unlicensed personnel (ULP)-I prepare R4's medications from a prefilled medication box, put pills into a small medication cup and administer R4's medications.	01640		

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

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01640	Continued From page 22 R4's Service Plan-Addendum to Contract dated June 30, 2025, included medication assistance; however, lacked indication R4 required weekly medication set up by the nurse. R5 R5's diagnoses included congested heart failure, respiratory failure and chronic kidney disease. R5's October 2025 Service Recap Summary indicated R5 was scheduled and received assistance with applying compression stockings daily. On October 28, 2025, at 8:36 a.m., the surveyor observed ULP-H applying R5's Tubigrips (compression stockings) to lower legs. R5's progress notes dated October 13, 2025, indicated the prescriber ordered the licensee's registered nurse (RN) to check R5's left big toe and burn on hands twice a week. R5's progress notes dated October 1, 8, 15, 22, indicated RN-C monitored R5's international normalized ratio (INR) (measures clotting of the blood). R5's Service Plan-Addendum to Contract dated August 6, 2024, lacked indication R5 received assistance with compression stockings and additional RN services to include weekly INRs and monitoring wounds twice a week. On October 29, 2025, at 2:23 p.m., CNS-B stated R5's service plan dated August 6, 2024, did not include R5's compression stockings or additional RN services for weekly INRs and wound monitoring twice a week. CNS-B stated she	01640		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

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01640	Continued From page 23 would print a new service plan and have R5 sign. R6 R6's diagnosis included diabetes type II. R6's October 2025 Service Recap Summary indicated R6 was scheduled and received blood glucose monitoring four times a day and daily weight monitoring. On October 28, 2025, at 8:01 a.m., the surveyor observed ULP-I administering R6's insulin, medications, monitor R6's blood glucose with a result of 191 and record R6's weight. R6's Service Plan-Addendum to Contract dated March 2, 2023, lacked indication R6 received blood glucose monitoring four times a day and daily weight monitoring. On October 30, 2025, at 9:15 a.m., RN-C stated R4's medications were set up weekly by RN-C and the ULPs administered R4's medications daily. CNS-B stated when R4 initially moved in, R4 did not receive any services from the licensee. CNS-B reviewed R4's signed service plan dated June 30, 2025, and stated R4's service plan did not include weekly medication set up by the nurse. CNS-B stated R6's service plan had not been updated to include blood glucose monitoring four times a day and resident service plans should reflect current services being provided by the licensee. The licensee's Service Plan Modifications policy April 10, 2025, indicated when a resident at the licensee receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by	01640		

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01640	Continued From page 24 the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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

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01700	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R4) who received medication management services. The findings include: During the entrance conference on October 27, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with the assisted living regulations and provided medication management services to residents at the facility. R4's diagnoses included Alzheimer's Disease and dementia. R4's Service Plan-Addendum to Contract dated June 30, 2025, indicated R4 received assistance with medications; however, lacked R4 required weekly medication set up by the nurse. On October 28, 2025, at 6:29 a.m., the surveyor observed unlicensed personnel (ULP)-I prepare R4's medication from a prefilled medication box and administer R4's medications. R4's September and October 2025, Medication Administration Summary, indicated R4's was scheduled and received medication administration by the licensee. R4's After Visit Summary dated October 17, 2025, included orders for the following	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

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01700	Continued From page 26 medications: -simethicone 125 milligrams (mg) (for excess gas) ; -senna-docusate 8.6-50 mg (for constipation); -tamsulosin 0.5 mg (for prostate); -sertraline 50 mg (for depression); -aledronate 70 mg (for bone density); -lidocaine 4% patch (for pain); -vitamin B complex vitamin (supplementation); -flucicasone nasal spry 50 micrograms (mcg) (for allergies); and -donepezil 10 mg (for memory). R4's record and comprehensive assessments dated May 1, 2025, and June 2, 2025, lacked a reassessment to include: - an identification and review of all medications the resident is known to be taking; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On October 30, 2025, at 9:15 a.m., CNS-A stated R4's record did not address the above required medication assessment information and was not included on the assessment forms being utilized for R4. The licensee's Medication Management Assessment, Monitoring, and Reassessment policy dated April 10, 2024, indicated prior to providing medication management the licensee would have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services would be provided and how the services would be provided. The assessment would be conducted face-to-face,	01700		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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01700	Continued From page 27 include identification and review of all medications the resident was known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address the issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 28 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan to include all required content for one of three residents (R4). 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:	01730		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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01730	Continued From page 29 R4's diagnoses included Alzheimer's Disease and dementia. R4's Service Plan-Addendum to Contract dated June 30, 2025, indicated R4 received assistance with medications; however, lacked R4 required weekly medication set up by the nurse. On October 28, 2025, at 6:29 a.m., the surveyor observed unlicensed personnel (ULP)-I prepare R4's medication from a prefilled medication box and administer R4's medications. R4's record included comprehensive assessments completed on May 1, 2025, and June 2, 2025, which indicated R4's medications were being managed by R4's spouse. R4's record lacked an individualized medication management plan to address how R4's medications were being stored, responsible party for ordering R4's medications and updated to include the licensee was managing and administering R4's medications. On October 30, 2025, at 9:14 a.m., clinical nurse supervisor (CNS)-B stated R4's record had not been updated to reflect the licensee was managing R4's medications including medication storage or responsible party for reordering R4's medications. The licensee's Medication Management Individualized Plan policy dated April 1, 2024, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the	01730		

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

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01730	Continued From page 30 following: -a statement describing the mediation management services that would be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions Documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and -the medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01760		

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01760	Continued From page 31 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately transcribe the prescriber orders onto the electronic medication administration record (EMAR) for one of four residents (R6). In addition, the licensee failed to ensure ULPs followed the medication administration procedure for two of two residents (R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on October 27, 2025, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication	01760		

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01760	Continued From page 32 management to residents at the facility. TRANSCRIPTION ERROR R6's diagnosis included bipolar disorder. R6's Service Plan-Addendum to Contract dated March 2, 2023, indicated R6 received assistance with medications five times a day. R6's Provider Orders dated September 24, 2025, included orders for divalproex extended release (ER) (to treat bipolar disorder) two tablets at bedtime. On October 28, 2025, at 8:01 a.m., the surveyor observed ULP-I prepare R6's medications from the Parata pack (medication set up system in individual pouches by the pharmacy) which include divalproex ER 500 mg one tablet and administer R6's medications. R6's October 2025 Medication Administration Summary indicated the following: -October 1, 2025, through October 28, 2025, indicated R6 was to receive divalproex ER 500 mg two tablets at bedtime then on October 29, 2025, directions changed divalproex ER 500 mg to one tablet at bedtime. On October 30, 2025, at 12:50 p.m., CNS-B stated CNS-B worked on the medication cart on September 29, 2025, and noticed R6's medication Parata pack directions were different from R6's directions on R6's Medication Administration Summary. CNS-B stated R6's directions on the Medication Administration Summary indicated divalproex ER two tablets and the Parata packet directions indicated	01760		

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01760	Continued From page 33 divalproex ER one tablet and there was only one tablet in the Parata pack. CNS-B stated at that time, CNS-B called the pharmacy and confirmed prescriber order dated June 11, 2025, was for divalproex ER one tablet at bedtime so, CNS-B changed R6's record to reflect divalproex ER one tablet at bedtime. CNS-B stated the licensee was unable to find the signed prescriber order for divalproex one tablet at bedtime and obtained an electronic prescription from the pharmacy via fax on October 30, 2025. CNS-B stated she was unsure whey R6's directions on the Medication Administration Summary were for divalproex two tablets instead of one. CNS-B stated a request was sent to R6's provider to clarify divalproex order and is waiting a response. The licensee's Medications and Treatment Orders policy dated January 27, 2025, indicated the RN was responsible for assuring current, authorized prescriber offers for medications and treatments administered by staff are kept on file in each resident records, communicated and provide education to the resident or responsible part, and addressed the resident's service plan and communicated to staff. The resident's medication and treatment administration records would be audited regularly for documentation compliance. NOT FOLLOWING MEDICATION PROCEDURE R4 R4's diagnoses included Alzheimer's Disease and dementia. R4's Service Plan-Addendum to Contract dated June 30, 2025, included medication assistance. R4's After Visit Summary (AVS) dated October	01760		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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01760	Continued From page 34 17, 2025, included to apply lidocaine 4% patch onto the skin every 24 hours and remove after 12 hours and the apply a new patch to right lower back. On October 28, 2025, at 6:29 a.m., the surveyor observed unlicensed personnel (ULP)-I prepare R4's medication from a prefilled medication box and administer R4's medications. The surveyor did not observe ULP-I offer to apply R4's lidocaine patch. Immediately after the medication observation, ULP-I stated R4 did not have any lidocaine patches and planned to notify the nurse. R4's Medication Administration Summary dated October 2025, indicated R4 did not received the lidocaine patch on October 8, 24, 27, and 28, and documentation in R4's record indicated R4's lidocaine patch was "not available" or "OOS" (out of stock). On October 29, 2025, at 2:58., CNS-B stated the ULPs had not informed nursing R4 did not have lidocaine patches to apply and contacted the pharmacy that day to re-order. CNS-B stated it was the expectation, when a resident's medication supply was running low to inform nursing to re-order. R6 R6's Provider Orders dated September 24, 2025, included lidocaine 4% patch apply to lower back in the AM and remove in PM. On October 28, 2025, at 8:01 a.m., the surveyor observed ULP-I administering R6's medications, insulin, and monitor R6's blood glucose. The surveyor did not observe ULP-I offer to apply	01760		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

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01760	Continued From page 35 R6's lidocaine patch. At 8:19 a.m., ULP-I stated ULP-I did not put on R6's lidocaine patch because R6 did not have any patches available, and the nurses were aware. R6's October 2025 Medication Administration Summary directed to apply lidocaine 4% patch in the AM and remove in the PM. R6's October 2025 Medication Summary indicated 27 out of 28 days, R6's lidocaine patch had not been applied as directed and was documented "OOS" (out of stock) 23 of the days and four of the days documented "resident declined". R6's record lacked documentation the ULPs had notified the nurse R6's lidocaine patches were out of stock or had been re-ordered from the pharmacy. R6's Progress Notes dated October 29, 2025, written by CNS-B indicated R6's pharmacy had not been refilling R6's lidocaine since 2024, and directed staff to contact the nurse if staff were documenting "OOS" (out of stock). If a resident has medications stored in their rooms and self-administers, the licensee must obtain an order from the prescriber, otherwise, staff is to administer all medications. On October 30, 2025, at 12:14 p.m., registered nurse (RN)-C stated RN-C was unaware R6's had not been receiving her lidocaine patches as ordered and would have to contact the pharmacy. CNS-B stated staff should be following the medications administration procedure and notifying the nurses if a resident was refusing medications or if mediations were not available. The licensee's Medication Management-Administration and Setup policy	01760		

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

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01760	Continued From page 36 dated April 10, 2025, indicated ULPs would chart in each resident's medication administration record any problems medication administration, including refusals. ULPs would also document any reason why medication administration was not completed as prescribed and document and follow-up procedures that were provided to meet the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure documentation of medication setup included all the required content for one of one resident (R4) observed for medication setup. 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	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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01770	Continued From page 37 a large portion or all of the residents). The findings include: During entrance conference on October 27, 2025, from 9:54 a.m. to 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with 144G statutory requirements. R4's diagnoses included Alzheimer's Disease and dementia. R4's Service Plan-Addendum to Contract dated June 30, 2025, indicated R4 received assistance with medications; however, lacked R4 required weekly medication setup by the nurse. On October 28, 2025, at 6:28 a.m., the surveyor observed ULP-I prepare R4's mediations from a prefilled weekly medication dosage box. ULP-I placed pills into single disposable medication cup and administer R4's medications. ULP-I stated when medications were setup by the RN, the residents Medication Administration Summary did not identify each pill. ULP-I stated ULP-I would count how many medications were set up in the medication dosage boxes and verify how many medications were listed on the resident's Medication Administration Summary to make sure the numbers of pills were the same. ULP-I stated if the number of pills were different there was no way to determine what medication was missing and would have to call the nurse. R4's October 2025 Medication Administration Summary used for documentation of medication set up consisted of the name of each medication, dosage, route, times to be administered, and signature and title of person who completed the	01770		

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	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

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01770	Continued From page 38 medication set up; however, lacked how may days each medication was set up. Resident medication set up documentation was not in there resident record or available to ULPs at the time of the medication administration and were kept in separate files in the nurses office. On October 28, 2025, at 9:01 a.m., the surveyor observed RN-C set up resident medications in weekly medication pill planners. RN-C stated she did not specifically document how many days each medication was set up for and was unfamiliar with the required content pertaining to medication setup. RN-C stated RN-C documented resident medication setup in different areas, on a separate paper medication administration record (MAR), resident's medication lists and sometimes makes notes on paper. The licensee's Medication Management-Dosage Box Setup policy dated April 10, 2024, indicated a licensed nurse would assure medications orders were transcribed onto the Medication Administration Record (MAR) to include; -dates of medication se up Medication name; -quantity of dose; -times to be administered route of administration; -name of the person completing the medication setup visual description of medication; and -drug classification and special precautions. The licensed nurse setup medications weekly into the dosages boxes. When the licensed nurse has completed the medication setup into the dosage box, the setup is documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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01770	Continued From page 39 days	01770		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure current written or electronically recorded prescriptions were obtained for two of three residents (R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on October 27, 2025, at 9:54 a.m., through 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R5 R5's diagnoses congested heart failure,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 40 respiratory failure and chronic kidney disease. R5's Service Plan-Addendum to Contract dated August 6, 2024, indicated R5 required medication set up by the RN and medication administration. R5's October 2025 Service Recap Summary indicated R5 was scheduled and received medication administration. On October 28, 2025, at 8:38 a.m., the surveyor observed ULP-H administer R5 the following medications via Parata pack system (medication set up system in individual pouches by the pharmacy): -aspirin 81 milligrams for atrial fibrillation; -Benefiter two teaspoons; mixed with six ounces of water; -bumex 1 mg for congestive heart failure; -cefadroxil 500 mg one capsule for urinary tract infections; -famotidine 20 mg one tablet for gastric reflux; -Lantus 25 units injection (long acting insulin); -oxybutynin 10 mg one tablet; for overactive bladder; -paroxetine 10 mg one tablet for depression; -Solonpas one patch to right knee every morning for pain; -spironolactone 25 mg one tablet for congestive heart failure; and -potassium chloride 20 milliequivalent (mEg) for supplementation. R5's After Visit Summary dated July 28, 2025, identified by CNS-B and RN-B as the current prescriber orders, included the medications noted above; however, it lacked a prescriber's signature.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 41 On October 30, 2025, at 9:59 a.m., RN-C stated with any changes in resident medications or treatments, the licensee accepted the After Visit Summary (AVS) as orders even if the AVS did not have a prescriber's signature. RN-C stated R5's AVS did not include a written or electronic signature from the provider. RN-C stated she would have to contact the pharmacy to obtain prescriptions for all of R5's medications. R6 R6's diagnosis included bipolar disorder. R6's Service Plan-Addendum to Contract dated March 2, 2023, indicated R6 received assistance with medications five times a day. R6's Provider Orders dated September 24, 2025, included orders for divalproex extended release (ER) (to treat bipolar disorder) two tablets at bedtime. R6's October 2025 Medication Administration Summary indicated October 1, 2025, through October 28, 2025, indicated R6 was to receive divalproex ER 500 mg two tablets at bedtime then on October 29, 2025, directions changed divalproex ER 500 mg to one tablet at bedtime. On October 28, 2025, at 8:01 a.m., the surveyor observed ULP-I prepare R6's medications from the Parata pack (medication set up system by the pharmacy) which include divalproex ER 500 mg one tablet and administer R6's medications. R6's resident record lacked a signed prescription for divalproex ER one tablet at bedtime. On October 30, 2025, at 12:50 p.m., CNS-B	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 42 stated CNS-B worked on the medication cart on September 29, 2025, and noticed R6's medication Parata pack directions were different from R6's directions on R6's Medication Administration Summary. CNS-B stated R6's directions on the Medication Administration Summary indicated divalproex ER two tablets and the Parata packet directions indicated divalproex ER one tablet and there was only one tablet in the Parata pack. CNS-B stated at that time, CNS-B called the pharmacy and confirmed prescriber order dated June 11, 2025, was for divalproex ER one tablet at bedtime so, CNS-B changed R6's record to reflect divalproex ER one tablet at bedtime. CNS-B stated they were unable to find a signed prescription in R6's record for divalproex one tablet at bedtime and had to contact the pharmacy to request the prescriber's order. The licensee's Medication and Treatment Orders policy dated January 27, 2025, indicated the RN was responsible for assuring that current, authorized prescriber orders for medication and treatments administered by the staff were kept on file in the resident's records. An order for medications or treatment must be dated, signed by the prescriber and must be current and consist with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	10/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 43 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 record all of the required content in the disposition of medications for one of one resident (R1) 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:	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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SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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01910	Continued From page 44 R1's diagnoses included heart disease, chronic kidney disease and mild cognitive impairment. R1's September 2025, Medication Administration Record (MAR) indicated R1 was scheduled and received the following medications: -allopurinol 100 milligrams used to treat symptoms of gout; -aspirin 81 mg for heart health; -calcitriol 0.25 micrograms (mcg) for low calcium levels; -furosemide 20 mg for fluid retention ; -lactulose solution for constipation; -tamsulosin 0.4 mg for enlarged prostate; and -melatonin 3 mg for sleep. R1's progress note dated September 12, 2025, indicated R1 moved to a higher level of care facility and R1's medications were given to R1's family. R1's Discharge/Transfer Summary dated September 17, 2025, indicated R1's services were initiated August 16, 2016, and included medication management. R1's Medication Disposition record dated September 11, 2025, included documentation for the disposition of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff involved in the disposition for R1's lorazepam (anti-anxiety), haloperidol (antipsychotic) and hydromorphone (pain reliever); however, R1's record lacked documentation of the disposal of R1's scheduled medications listed on R1's September 2025, MAR noted above.	01910		

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

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01910	Continued From page 45 On October 27, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated they were unable to find documentation of R1's disposition of medications noted above and was aware of the requirement. Registered nurse (RN)-C stated RN-C recalled completing R1's medication disposition record and must have given the list with R1's medications at the time of discharge. The licensee's Medication Disposal policy dated January 27, 2025, indicated current unused medications managed by the licensee would be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications were no longer managed by the facility, or the medication has been discontinued by the prescriber. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 46 and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by unlicensed personnel (ULP)-I for one of one resident (R6) whose medications were not administered as directed. 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-I was hired August 8, 2016, to provide care and services to the residents at the facility. ULP-I's employee record indicated ULP-I completed medication training and passed a competency skills test by the registered nurse (RN) on July 12, 2018. R6's Service Plan-Addendum to Contract dated March 2, 2023, indicated R6 received assistance with medications five times a day. R6's comprehensive assessment dated September 23, 2025, indicated R6 was unable to self-administer medications, and all medications	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 47 would be managed and administered by the licensee. R6's provider orders dated September 24, 2025, included Tums (antacid) 500 milligrams (mg) three times a day with meals and diclofenac 1% gel (pain reliever) to left knee twice a day. R6's October 2025 Medication Administration Summary included diclofenac 1% gel apply to left knee twice daily and Tums one tablet with meals. R6's record did not indicate R6's was able to keep medications in room or self-administer. In addition, R6's Medication Admission Summary included documentation R6 self-administered diclofenac gel. On October 28, 2025, at 8:01 a.m., the surveyor observed ULP-I prepare R6's medications from the Parata pack (medication set up system by the pharmacy) and administer R6's medications. During the medication observation, the surveyor did not observe ULP-I administer R6's diclofenac gel or Tums. At 8:19 a.m., ULP-I documented in R6's Medication Administration Summary, ULP-I administered R6's medications and documented R6 received Tums and diclofenac gel. ULP-I stated R6 kept Tums and diclofenac in her room to self-administer. ULP-I stated R6's record did not indicate R6's was able to self-administer any medications or treatments. ULP-I stated staff just knew R6 self-administered Tums and diclofenac gel. On October 30, 2025, at 1:07 p.m., clinical nurse supervisor (CNS)-B stated R6 was not assessed to self-administer any medications or store medication in R6's room and ULPs should be following the directions on resident's Medication	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 48 Administration Summary. CNS-B stated if a resident was assessment by the nurse to self-administer medications, orders would be obtained from the provider, and directions would be indicated on the Medication Administration Summary. The licensee's Medication and Treatment-Administration and Delegation policy dated April 10, 2024, indicated prior to providing delegated medication administration, the following must occur: -a RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided; -the licensee would prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that will be provided to the resident; -the medications have current prescriber's orders on file; -a RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record; -a RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 49 administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Saint Ann'S Home
330 East 3rd Street
Duluth, MN 55805
Parcel:

Phone:

License Info

License: HFID 30434

Risk:
License:
Expires on:
CFPM: Sandy Lewis
CFPM #: 36670; Exp: 5/9/2028

Inspection Info

Report Number: F7980251089
Inspection Type: Full - Joint
Date: 10/28/2025 Time: 10:30:54 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: SANDY'S CURRENT CFPM WAS NOT POSTED, IT WAS POSTED DURING INSPECTION
Comply By: Complied On Site Originally Issued On: 10/28/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: TILE FLOOR IN THE WALK IN FREEZER IS BROKEN ALONG A CRACK. REPLACING WITH NEW TILE IS NOT RECOMMENDED SINCE IT WILL CRACK AGAIN. DIAMOND PLATE, STAINLESS OR EPOXY WOULD BE A BETTER SOLUTION. CALL FOR APPROVAL BEFORE REPLACING FLOOR
Comply By: 10/28/2028 Originally Issued On: 10/28/2025

Food & Beverage General Comment

Notes
1. Inspection was part of a HRD survey with Sativa Bushey
2. No pests were noticed during the inspection in the main kitchen or serving kitchen on the second floor. There have been fruit flies in the past and staff were instructed on how to handle food to avoid an infestation.
3. Pasteurized eggs provided for any undercooked egg dishes
4. Discussed employee illness procedures, anyone ill with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. Illness log is kept. Illness information will be emailed with the report
5. Food safety handouts and certified food manager information will be emailed to the facility
6. Sheet metal solutions is the only NSF fabricator in the area they could install stainless or diamond plate in the walk in freezer. Another option is a prefabricated insulated floor panels or epoxy. Call for approval before installing flooring. The tile could be patched but will most likely crack again. Invalid Value

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F7980251089 from 10/28/2025

Sara Bents

Pat Messina
Food Service Director

Sara Bents,
Public Health Sanitarian 3
218-302-6184
sara.bents@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Saint Ann'S Home
Duluth
County/Group:

Inspection Info

Report Number: F7980251089
Inspection Type: Full
Date: 10/28/2025
Time: 10:30:54 AM

Food Temperature: Product/Item/Unit: Main-Grape tomatoes**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Diced potatoes for soup**; Temperature Process:** Cooling
Location: Walk-in Cooler at 46 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hash browns**; Temperature Process:** Thawing
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Bologna**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Dairy-hard boiled eggs**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Provolone**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Chocolate milk**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Artic Air-OJ**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: All items frozen hard**; Temperature Process:** Cold-Holding
Location: Walk-in Freezer at Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: Saturn 2nd floor dining-chocolate milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: 2nd floor dining-pizza**; Temperature Process:** Hot-Holding
Location: Cambro at 150 Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

Saint Ann'S Home
Duluth
County/Group:

Inspection Info

Report Number: F7980251089
Inspection Type: Full
Date: 10/28/2025
Time: 10:30:54 AM

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 162 Degrees F.
Comment: Dish machine wash
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 182 Degrees F.
Comment: Dish machine rinse thermo label black
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7980251089

Food Establishment Inspection Report

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

No. of Risk Factor/Intervention/Violations	1	Date: 10/28/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30:54 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Saint Ann'S Home	330 East 3rd Street	Duluth, MN	55805	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30434		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	OUT	Certified Food Protection Manager	X	
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

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

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

			COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature) Sara Bents

Follow-up: Follow-up Date: