Electronically Delivered

August 25, 2022

Administrator
Stanton House With Services Incorporated
4847 Bryant Avenue North
Minneapolis, MN 55430

RE: Project Number(s) SL32730015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

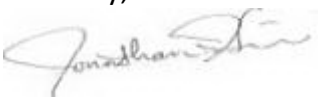
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32730015 On, August 1 through August 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 2, 2022, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment (PPE) was worn in the facility and while providing cares. This had the potential to affect all six (6) 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	0 510		

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0 510	Continued From page 3 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: COVID PPE On August 1, 2022, at 10:15 a.m., upon entrance to the facility, unlicensed personnel (ULP)-C was observed to assist R1 with treatment to R1's lower legs. ULP-C wrapped R1's lower legs with gauze, and applied a Velcro compression garment to both lower legs. ULP-C failed to wear eye protection while assisting R1. On August 1, 2022, at 11:37 a.m., during a tour of the facility, licensed assisted living director (LALD)-B and registered nurse (RN)-A were both observed to wear their facemask covering only their mouth, leaving the nose exposed, for the duration of the tour. On August 1, 2022, at 12:51 p.m., RN-A stated she was responsible for infection control for the licensee. RN-A further stated staff wore masks at all times while in the facility, but did not wear eye protection. House manager (HM)-D stated they have a supply of face shields available. HM-D further stated some staff wore full PPE while providing assistance with bathing, but it was not required. On August 1, 2022, at 12:56 p.m., LALD-B entered the facility. LALD-B was observed wearing a facemask below her mouth, around her chin while talking with other staff and the survey team. On August 2, 2022, at 8:40 a.m., ULP-C was	0 510		

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0 510	Continued From page 4 observed to assist R1 with medication administration. ULP-C wore a face mask, but failed to wear eye protection while assisting R1. On August 2, 2022, at 9:33 a.m., ULP-C was observed to assist R1 with activities of daily living, wound care, and changing leg wraps. ULP-C failed to wear eye protection while assisting R1. On August 2, 2022, at 1:20 p.m., LALD-B acknowledged staff had not been wearing the appropriate PPE for the healthcare setting. Surveyors provided education on PPE requirements and using the MDH PPE grid and CDC COVID data tracker. LALD-B expressed understanding of the requirements. HAND HYGIENE/GLOVES On August 2, 2022, at 12:12 p.m., during a medication administration observation, ULP-C reviewed the medication administration record, and prepared R2's medications. ULP-C performed hand hygiene by rubbing hands together with soap for 6 seconds before rinsing under running water. ULP-C assisted R2 with oral medications, and R2 self-administered an intranasal medication. ULP-C then administered R2's Olopatadine (eye medication for itching and redness), one drop to each eye. ULP-C failed to perform hand hygiene and don gloves prior to assisting R2 with eye medication. ULP-C assisted R2 with an oral rinse, documented medication administration, and secured the medication cabinet. ULP-C was observed to perform hand hygiene by rubbing hands together with soap for 6 seconds before rinsing under running water. On August 2, 2022, at 9:50 a.m., ULP-C was observed to assist R1 with treatment to the left lower leg. ULP-C removed a soiled dressing. R1's	0 510		

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0 510	Continued From page 5 skin was observed to have multiple open wounds with serous drainage related to edema. ULP-C performed wound care and replaced a dressing to R1's left lower leg. ULP-C failed to don clean gloves before she applied the clean dressing to R1's lower leg. On August 2, 2022, at 1:56 p.m., RN-A indicated staff were trained to perform hand hygiene for 20 seconds. RN-A stated it would be her expectation that gloves be worn when administering eye drops. RN-A further stated she would expect gloves to be changed after removing a soiled dressing, prior to applying a clean dressing. RN-A added changing gloves during wound care would be included in upcoming training. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection.	0 510		

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0 510	Continued From page 6 The CDC COVID Data Tracker on August 1, 2022, and August 2, 2022, indicated Hennepin County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for one of six residents (R1) with records reviewed. This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's Care Plan, dated February 10, 2022, indicated R1 required assistance with meals, grooming, bathing, laundry, transfers, dressing, and medication management. The Care Plan did not identify vulnerabilities or interventions to minimize the risk of abuse. R1's record included a vulnerable adult assessment completed February 10, 2022. The assessment identified R1's vulnerabilities as self-abuse and financial exploitation. The assessment lacked specific measures to be taken by staff to minimize the risk of abuse. R1's record lacked an IAPP that contained statements of the specific measures to be taken by staff to minimize the risk of abuse. On August 1, 2022, at 2:48 p.m., registered nurse (RN)-A confirmed R1 had a vulnerable adult risk assessment but interventions were not documented. On August 1, 2022, at 3:41 p.m., RN-A and licensed assisted living director (LALD)-B verified R1's record lacked and IAPP with interventions to address the areas of vulnerability identified on the vulnerable adult assessment.	0 630		

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0 630	Continued From page 8 The licensee's undated Abuse Prevention Plan, undated, indicated, "all residents admitted to [Licensee] will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. [Licensee] will develop a statement of specific measure that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 9 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for one of two employees (unlicensed personnel (ULP)-C) and documentation of dementia care training for one of two employees (registered nurse (RN)-A) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: ULP-C ULP-C was hired August 28, 2019, and provided	0 650		

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0 650	Continued From page 10 direct care services for the residents of the facility. ULP-C's employee record lacked documentation of annual performance reviews completed since hire. During an interview on August 1, 2022, at 3:23 p.m., house manager (HM)-D confirmed there was not a current performance review completed for ULP-C. HM-D stated she used to do annual performance reviews for staff, but did not like the form, so was looking for a new one. RN-A RN-A was hired February 28, 2022, and provided supervisory and direct care services for residents of the facility. RN-A's employee record lacked documentation of eight hours of dementia care training in the required topics completed within 80 working hours of hire. On August 2, 2022, at 11:41 a.m., RN-A stated she had extensive dementia care training November of 2021, when she took a course on dementia, Parkinson's and Alzheimer's disease as part of her advanced nursing degree. RN-A further stated she had dementia care training through online modules during her previous employment with another long-term care provider. RN-A verified her employee record lacked documentation of dementia care training and indicated the licensee did not request documentation of her dementia care training upon hire. The licensee's undated employee records policy indicated, "Employee records must include the	0 650		

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STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430

(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
0 650	Continued From page 11 following information: -Evidence of current professional licensure, registration, or certification if licensure, registration or certification is required; -Records of orientation, required annual training, infection control training and competency evaluations; -Current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision; -Documentation of annual performance reviews that identify areas of improvement needed and training needs; -For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those screenings; and -Documentation of the background study as required under section 144.057." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	0 660		

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0 660	Continued From page 12 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of education, baseline testing and history and symptom screening for one of two employees (registered nurse (RN)-A) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: The facility TB risk assessment dated March 7, 2022, indicated the facility was a low risk setting for TB transmission. RN-A was hired February 28, 2022, and provided supervisory and direct care services for residents of the facility. RN-A's employee file lacked documentation of a TB history and symptom screening form and documentation of a TB test completed upon hire.	0 660		

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0 660	Continued From page 13 Further, RN-A's file lacked documentation of TB infection control training completed upon hire. During an interview on August 2, 2022, at 12:11 p.m., RN-A stated she had no TB training as a part of this position. RN-A further stated she was screened for TB at her previous job, and also had TB testing completed as a requirement for her education program, but did not recall completing screening for her position at this facility. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's undated Tuberculosis Screening policy indicated, "Each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on facility risk assessment or a negative IGRA (blood test)." The licensee's undated Tuberculosis Prevention	0 660		

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0 660	Continued From page 14 and Control policy indicated, "Training and information will be provided for all employees and volunteers at the time of employment and annually during infection control in-services. This training will inform the employees of the following: 1) Signs and symptoms of TB 2) Health screening and therapy 3) Facility specific protocols 4) Use of respiratory protection equipment" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 15 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all six (6) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 1, 2022, the "[Licensee] Emergency Preparedness Manual" dated June 21, 2022, was reviewed. The provided EP plan lacked individualized emergency procedures to include the following: - risk assessment; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - an assessment of at-risk population's needs; - categorize the various probable risks/hazards by likelihood of occurrence - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans)	0 680		

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0 680	Continued From page 16 - a process for emergency preparedness cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - the medical record documentation system to preserve resident information; - means of releasing and providing resident information in the event of an evacuation; - means to providing information about occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - handling and use of volunteers; - plan to address food, water, medical supplies, and pharmaceutical supplies; - alternate sources of emergency and standby power systems to help maintain safe temperature, sanitation, emergency lighting, fire detection, sewage; - include a process for cooperating and collaboration with local tribal, regional, state, and federal EP to maintain integrated response; - EP training and testing program; - conducting exercises to test the EP at least twice per year; - participation in annual full-scale exercises; - analyze responses to and maintain documentation of all drills; - how the [licensee] would operate under an 1135 waiver; - a written communication plan that included: - names and contact information for staff, resident physicians, other facilities; and - a method of sharing information and medical documentation for residents. - contact information for Federal, State, tribal, regional, and local EP staff - State Licensing and Certification Agency - other sources of assistance	0 680		

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0 680	Continued From page 17 On August 1, 2022, at 12:54 p.m. the housing manager (HM)-D stated they provided all the EP information they had available. HM-D agreed their EP plan was lacking information which would make it unique to their facility and residents. On August 2, 2022, at 1:20 p.m., the licensed assisted living director (LALD)-B confirmed they provided all the EP information they had available. LALD-B agreed their EP plan was lacking information which would make it unique to their facility and residents. The licensee's undated Emergency Management policy indicated, "[Licensee] will have an identified plan in place to ensure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." The policy further indicated the purpose of the EP was, "to establish guidelines for resident care during periods of emergency or disaster, provide direction and instruction for staff, identify the process for disaster readiness and emergency management, and to establish a structure that identifies the facility relationship to the community wide emergency management program." The licensee's undated Hazard Vulnerability Assessment policy, indicated, "The proactive risk assessment or Hazard Vulnerability Analysis (HVA) will be performed using an all-hazards approach to identify possible emergency events the facility could experience that could interfere with the delivery of care and services. The assessment also will evaluate how the facility's essential business functions and ability provide services could be impacted by those emergent events."	0 680		

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0 680	Continued From page 18 No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include:	0 790		

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0 790	Continued From page 19 On August 2, 2022, from approximately 11:50 a.m., to 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the installed portable fire extinguisher was size 5:BC. There was no annual inspection tag and no monthly inspection tag. RN-A verbally confirmed survey staff observations during the facility tour. Survey staff explained that the monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical	0 800		

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0 800	Continued From page 20	0 800		

environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.

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

The findings include:

On August 2, 2022, from approximately 11:50 a.m. to 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following:

Bathroom #3
1. The exhaust fan was covered in lint and dust.
2. The wall by the light switch was damaged and in need of repair.
3. The sealant around the sink was damaged. Water was observed behind the paint around the sink. The paint was bubbling and pulling away from the wall.
4. The wood base by the shower was damaged by water and pulling away from the wall. This caused the mitered joint to open exposing sharp edges of the wood.

Hallway
1. The walls, trim, and doors were all damaged in the hallway by a resident with an electric scooter.
2. The floor outside bathroom #3 had water damage. The laminate plank flooring was warped and some of the top material was coming off of

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0 800	Continued From page 21 the floor. Bedroom #5 1. The floor inside bedroom #5 was damaged and could be a possible trip hazard. 2. The door trim was loose around the entrance door. The door frame had also come loose and there were protruding nails from the wood. Bedroom #6 1. There were protruding nails from the door frame near the latch. Bathroom #2 1. The wood base by the shower was damaged by water and pulling away from the wall. This caused the mitered joint to open exposing sharp edges of the wood. 2. The sealant around the sink was damaged. Water was observed behind the paint around the sink. The paint was bubbling and pulling away from the wall. 3. There was standing water next to the toilet from a possible leak. Living/ Dining Room 1. There was damage to the walls from the electric scooter. 2. The screen frame in one of the windows in the dining room was bent and allowed flies into the facility. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 22	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the	0 810		

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0 810	Continued From page 23 licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on August 2, 2022, at 1:15 p.m., the licensed assisted living director (LALD)-B stated they had not done any drills or training since August 1, 2021. Review of the "Fire Emergency" policy showed: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No record of required employee evacuation drills.	0 810		

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0 810	Continued From page 24 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930		

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0 930	Continued From page 25 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee Assisted Living Contract did not include the right to appeal termination of the Assisted Living Contract for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted February 10, 2022, and received services including assistance with meals, grooming, bathing, laundry, transfers, dressing, and medication management. R1's Assisted Living Contract, signed February 10, 2022, lacked a clear and conspicuous notice of: -the right under section 144G.54 to appeal the termination of an assisted living contract. On August 1, 2022, licensed assisted living director (LALD)-B acknowledged the current contract lacked a notice of the right to appeal termination of the contract. LALD-B verified all current residents received the same contract. No further information was provided.	0 930		

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	32730	A. BUILDING: _____ B. WING _____	08/02/2022

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0 930	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all six (6) residents living at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted February 10, 2022, and received services including assistance with meals, grooming, bathing, laundry, transfers,	0 970		

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0 970	Continued From page 27 dressing, and medication management. The licensee's Assisted Living Contract, signed by resident (R1) on February 10, 2022, included the following language indicating waivers of liability: Page 7: -"Security/Valuables/Keys: All resident rooms have security locks. If you choose not to lock your valuables, you assume liability for them."; Page 11: -"Insurance: Each resident should maintain his or her own health, personal property, liability and other applicable insurance policies."; Page 15-16: -"Insurance Liability and Release: The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests, or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents.";	0 970		

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0 970	Continued From page 28 -"Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."; and -"Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On August 1, 2022, at 1:00 p.m., licensed assisted living director (LALD)-B acknowledged the waiver of liability language present in R1's contract. LALD-B indicated she would review this topic further for clarification of the statute regarding liability waivers. On August 2, 2022, at 1:20 p.m., LALD-B indicated all current residents received the same contract that contained the same language. The licensee's undated Assisted Living Contracts policy indicated, "The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract	0 970		

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0 970	Continued From page 29 must not include any provision that the facility knows or should know to be deceptive, unlawful or unenforceable under state or federal law." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01460		

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01460	Continued From page 30 of the residents). The findings include: The licensee converted to an Assisted Living license on August 1, 2021 RN-A was hired February 28, 2022, and provided supervisory and assessment services for the residents of the facility. RN-A's employee record lacked documentation RN-A completed all orientation to assisted living licensing requirements and regulations with the required content. ULP-C was hired August 28, 2019, under the licensee's comprehensive license, and began providing assisted living services August 1, 2021. ULP-C's employee record included updated orientation signed by RN-E (the licensee's previous RN) August 12, 2021. The orientation lacked following assisted living topics: - Overview of Assisted Living statutes; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 1, 2022, at approximately 2:45 p.m.,	01460		

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01460	Continued From page 31 house manager (HM)-D stated ULP-C had orientation to home care when hired. HM-D further stated the orientation updated after August 1, 2021, included assisted living topics, although, the old form with home care topics listed was used to document the orientation. HM-D indicated the orientation provided regarding the Assisted Living Bill of Rights would have also included information regarding consumer advocacy and the ombudsman. On August 1, 2022, at 3:14 p.m., ULP-C stated she recalled receiving updated orientation on the Assisted Living Bill of Rights, but further indicated she did not fully understand assisted living laws related to consumer advocacy and the ombudsman. On August 2, 2022, at 11:41 a.m., RN-A confirmed she had not received orientation to assisted living. RN-A indicated RN-E was busy and unable to provide the training prior to leaving. The licensee's undated Facility Employee Orientation policy indicated, "All employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the Facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. If any volunteers provide services to assisted living residents, they also will receive required orientation." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		

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01500	Continued From page 32	01500		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on	01500		

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01500	Continued From page 33 providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01500		

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01500	Continued From page 34 ULP-C was hired August 28, 2019, under the licensee's comprehensive license, and began providing assisted living services August 1, 2021. On August 1, 2022, at 12:12 p.m., ULP-C was observed to assist R2 with medication administration. ULP-C's record indicated training completed in the last 12 months lacked: -Principles of person-centered planning and service delivery On August 1, 2022, at 12:51 p.m., registered nurse (RN)-A stated she was responsible for orientation and training, but had not participated in providing annual training since she started working in February. RN-A stated annual training had been completed by the previous RN. The licensee's undated Annual Training Requirements policy indicated, "All staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment." The policy further indicated the training must include the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	01650		

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01650	Continued From page 35 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01650		

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01650	Continued From page 36 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's service plan, signed February 10, 2022, indicated R1 received services including assistance with meals, grooming, bathing, laundry, transfers, dressing, and medication management. R1's service plan lacked a contingency plan to include: -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On August 2, 2022, at 1:20 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B acknowledged R1's service plan did not include required information. RN-A indicated they would ensure R1's service plan was filled out completely when updated. The licensee's undated service plan policy indicated the service plan must jnclude a contingency plan with the following information: -the action to be taken by the provider if scheduled services cannot be provided;	01650		

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01650	Continued From page 37 -information and a method for a resident or their representative to contact the facility; -name and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and l 45C, and declarations made by the resident under those chapters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility 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	01730		

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01730	Continued From page 38 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 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 licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01730		

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01730	Continued From page 39 of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's service plan, dated February 10, 2022, indicated R1 received services including verbal reminders to take medications. On August 2, 2022, at 2:17 p.m., at 8:40 a.m., unlicensed personnel (ULP)-C was observed administering medications to R1. R1's medication management plan, dated February 10, 2022, incorrectly indicated R1 received set-up medications. The medication management plan lacked the following: -a statement describing the medication management services that will be provided (outdated information); -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; and -any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. On August 2, 2022, at 9:26 a.m., registered nurse (RN)-A verified R1's medication management plan incorrectly indicated R1 had medication set up by the RN. RN-A acknowledged the medication management plan needed updating	01730		

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	32730	A. BUILDING: _____ B. WING _____	08/02/2022

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01730	Continued From page 40 and was missing required information specific to the resident. The licensee's undated Individualized Medication Management Plan and Record policy indicated, "Following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following: a. A statement describing the medication management services that will be provided; b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; e. Identification of medication management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; g. Any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01820	Continued From page 41	01820		
01820 SS=D	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 licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's service plan, dated February 10, 2022, indicated R1 received services to include assistance with meals, grooming, bathing, laundry, transfers, dressing, and medication management. On August 2, 2022, at 8:40 a.m., unlicensed personnel (ULP)-C was observed to administer medications to R1.	01820		

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01820	Continued From page 42 R1's MAR for July and August 2022, indicated R1 was administered the following daily, or as needed (PRN), on July 1-31, August 1-2, 2022: -Gavilax (for constipation) 17 grams (gm); -hydrocortisone acetate-aloe 0.5%; -Xarelto (rivaroxaban-a blood thinner) 20 milligram (mg); -gabapentin 300 mg (for pain); -acetaminophen 975 mg (for pain); -omeprazole 20 mg (for acid reflux); -duloxetine 60 mg (an antidepressant); -trazodone 100 mg (for insomnia); -melatonin 3 mg (for insomnia); -clobetasol 0.05% PRN (for skin itching); -bisacodyl 10 mg rectal suppository PRN (for constipation); -Eucerin (for dry skin); -lisinopril 40 mg (for blood pressure); -clonidine 0.3 mg transdermal patch (for blood pressure); -milk of magnesia 30 milliliters (ml) (for constipation); -polyethyl glycol-propyl glycol eye drops; -cyclobenzaprine 5 mg (for muscle spasm); -albuterol inhaler PRN (for wheezing); -Asper creme Lidocaine patch (for pain); -carvedilol 6.25 mg (for blood pressure); -carboxmethyicellulose sodium 0.5% eye drops (for burning, irritation); and -atorvastatin 20 mg (for high cholesterol). R1's record lacked signed prescriber orders for the above listed medications. On August 2, 2022, at 1:20 p.m., registered nurse (RN)-A confirmed the orders they had listed were current, however did not have signed orders for R1.	01820		

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01820	Continued From page 43 The licensee's undated Medication Prescriptions and Refills policy, indicated, "The Facility RN will develop procedures for requesting and receiving medication prescriptions. A current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 44 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's Care Plan, dated February 10. 2022, indicated R1 had "bilateral edema" (swelling on both sides) and used "support hose/TEDS" (compression stockings). The care plan further indicated R1 required total assist with "special treatments". R1's record included a handwritten note dated	01940		

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01940	Continued From page 45 February 11, 2022, by registered nurse (RN)-E, that indicated, "[R1] legs to be wrapped daily". R1's record included an undated, unsigned note that indicated, "Velcro compression wraps for wound and edema management". Licensed assisted living director (LALD)-B stated the note was written for R1 July 5, 2022, by a physical therapist. R1's service plan dated February 10, 2022, indicated in the treatments section, "See Treatment Protocols/Flowsheet". The service plan lacked information related to wound care or edema treatments. R1's record lacked a treatment and therapy management plan regarding wound care and edema treatments to R1's lower legs. On August 1, 2022, at 10:15 a.m., upon entrance to the facility, unlicensed personnel (ULP)-C was observed to assist R1 with treatment to R1's lower legs. ULP-C wrapped R1's lower legs with gauze, and applied a Velcro compression garment to both lower legs. On August 2, 2022, at 9:50 a.m., ULP-C was again observed to assist R1 with treatment to the left lower leg. ULP-C removed a soiled dressing. R1's skin was observed to have multiple open wounds with serous drainage related to edema. ULP-C performed wound care and replaced a dressing to R1's left lower leg. On August 2, 2022, at approximately 8:45 a.m., unlicensed personnel (ULP)-C stated she received training on applying R1's leg wraps at a physical therapy appointment.	01940		

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01940	Continued From page 46 On August 2, 2022, at 9:21 a.m., LALD-B confirmed ULP-C was trained on how to apply R1's leg wraps at a physical therapy appointment, July 28, 2022. On August 2, 2022, at 10:16 a.m., LALD-B stated the previous RN (RN-E) trained ULP-C in applying ace wraps for R1 but verified there was no documentation of the training. On August 2, 2022, at 11:23 a.m., ULP-C stated staff at the facility had been assisting R1 with dressing changes and wound cares since R1 was admitted February 10, 2022. On August 2, 2022, at 9:26 a.m., RN-A confirmed there was no treatment management plan developed for R1. RN-A acknowledged the treatment management plan would need to be completed regarding the treatment services provided for R1. The licensee's undated Treatment and Therapy Management Plan policy indicated, "When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: -A written statement of the treatment or therapy that will be provided; -Documentation of specific instructions that relate to providing the treatment or therapy administration; -Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services; -Any resident-specific requirements that relate to	01940		

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01940	Continued From page 47 documentation of treatments and therapy, and direction on where tasks are to be documented; -Frequency of supervision of personnel providing the delegated treatment or therapy services; -Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions; -The treatment or therapy plan will be updated when there are changes; -The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01950		

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01950	Continued From page 48 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed and ensured competency of the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's Care Plan, dated February 10, 2022, indicated R1 had "bilateral edema" (swelling on both sides) and used "support hose/TEDS" (compression stockings). The care plan further indicated R1 required total assist with "special treatments". R1's record included a handwritten note dated	01950		

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01950	Continued From page 49 February 11, 2022, by registered nurse (RN)-E, that indicated, "[R1] legs to be wrapped daily". R1's record included an undated, unsigned note that indicated, "Velcro compression wraps for wound and edema management". Licensed assisted living director (LALD)-B stated the note was written for R1 on July 5, 2022, by a physical therapy provider. R1's service plan, dated February 10, 2022, indicated in the treatments section, "See Treatment Protocols/Flowsheet". The service plan lacked information related to wound care or edema treatments for R1. R1's record lacked a treatment and therapy management plan with instructions regarding wound care and edema treatments to R1's lower legs. On August 1, 2022, at 10:15 a.m., upon entrance to the facility, unlicensed personnel (ULP)-C was observed to assist R1 with treatment to R1's lower legs. ULP-C wrapped R1's lower legs with gauze, and applied a Velcro compression garment to both lower legs. On August 2, 2022, at 9:50 a.m., ULP-C was again observed to assist R1 with treatment to the left lower leg. ULP-C removed a soiled dressing. R1's skin was observed to have multiple open wounds with serous drainage related to edema. ULP-C performed wound care and replaced a dressing to R1's left lower leg. ULP-C failed to don clean gloves prior to applying the clean dressing. ULP-C's employee record lacked documentation ULP-C received training and demonstrated	01950		

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01950	Continued From page 50 competency assisting R1 with wound care and applying leg wraps. On August 2, 2022, at approximately 8:45 a.m., ULP-C stated she received training on applying R1's leg wraps at a physical therapy appointment. On August 2, 2022, at 9:21 a.m., LALD-B confirmed ULP-C was trained on applying R1's leg wraps at a physical therapy appointment, July 28, 2022. LALD-B did not provide documentation of the training. On August 2, 2022, at 10:16 a.m., LALD-B stated the previous RN (RN-E) trained ULP-C in applying ace wraps for R1 but verified there was no documentation of the training. On August 2, 2022, at 11:23 a.m., ULP-C stated staff at the facility had been assisting R1 with dressing changes and wound cares since R1 was admitted February 10, 2022. On August 2, 2022, at 9:26 a.m., RN-A confirmed there was no treatment management plan developed for R1. RN-A acknowledged the treatment management plan would need to be completed regarding the treatment services provided for R1. On August 2, 2022, at 1:56 p.m., RN-A stated she would expect gloves to be changed after removing a soiled dressing, prior to applying a clean dressing. RN-A added changing gloves during wound care would be included in upcoming training. The licensee's undated Treatment and Therapy Management Plan policy indicated, "When administration of a treatment or therapy is	01950		

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01950	Continued From page 51 delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse or authorized licensed health professional has: a. Instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedure; b. Specified in writing detailed instructions for each resident and documented the instructions in the resident's record; c. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (R1) with records reviewed.	01960		

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01960	Continued From page 52 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's Care Plan, dated February 10. 2022, indicated R1 had "bilateral edema" (swelling on both sides) and used "support hose/TEDS" (compression stockings). The care plan further indicated R1 required total assist with "special treatments". R1's record included a handwritten note dated February 11, 2022, by registered nurse (RN)-E, that indicated, "[R1] legs to be wrapped daily". R1's record included an undated, unsigned note that indicated, "Velcro compression wraps for wound and edema management". Licensed assisted living director (LALD)-B stated the note was written for R1 July 5, 2022, by a physical therapist. On August 1, 2022, at 10:15 a.m., upon entrance to the facility, unlicensed personnel (ULP)-C was observed to assist R1 with treatment to R1's lower legs. ULP-C wrapped R1's lower legs with gauze, and applied a Velcro compression garment to both lower legs.	01960		

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01960	Continued From page 53 On August 2, 2022, at 9:50 a.m., ULP-C was again observed to assist R1 with treatment to the left lower leg. ULP-C removed a soiled dressing. R1's skin was observed to have multiple open wounds with serous drainage related to edema. ULP-C performed wound care and replaced a dressing to R1's left lower leg. R1's record lacked documentation of wound care and assistance with leg wraps or compression garments. On August 2, 2022, at 9:19 a.m., ULP-C stated they documented assisting with R1's leg wraps by documenting in the areas that indicated assistance with dressing or personal cares. ULP-C further stated there is no documentation area specifically for leg wraps or wound care. On August 2, 2022, at 11:23 a.m., ULP-C stated staff at the facility had been assisting R1 with dressing changes and wound cares since R1 was admitted February 10, 2022. On August 2, 2022, at 10:29 a.m., licensed assisted living director (LALD)-B confirmed understanding treatments needed to be documented somewhere. LALD-B stated she would add the documentation to the medication administration record (MAR) since an order was required for the treatments. The licensee's undated Treatment and Therapy Management Plan policy indicated, "Each task (therapy or treatment) will be documented in the resident record. Each entry will include the signature and title of the person who administered the treatment and will include the date and time of administration. When the treatment or therapy is not administered as	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430

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01960	Continued From page 54 ordered, the facility will document the reason why it was not administered, communicate with prescriber as needed, and any follow up procedures that were provided to meet the resident need." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	08/02/2022

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01970	Continued From page 55 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted February 10, 2022. R1's Care Plan, dated February 10. 2022, indicated R1 had "bilateral edema" (swelling on both sides) and used "support hose/TEDS" (compression stockings). The care plan further indicated R1 required total assist with "special treatments". R1's record included a handwritten note dated February 11, 2022, by registered nurse (RN)-E, that indicated, "[R1] legs to be wrapped daily". R1's record included an undated, unsigned note that indicated, "Velcro compression wraps for wound and edema management". Licensed assisted living director (LALD)-B stated the note was written for R1 July 5, 2022, by a physical therapist. On August 1, 2022, at 10:15 a.m., upon entrance to the facility, unlicensed personnel (ULP)-C was observed to assist R1 with treatment to R1's lower legs. ULP-C wrapped R1's lower legs with gauze, and applied a Velcro compression garment to both lower legs. On August 2, 2022, at 9:50 a.m., ULP-C was again observed to assist R1 with treatment to the left lower leg. ULP-C removed a soiled dressing. R1's skin was observed to have multiple open wounds with serous drainage related to edema. ULP-C performed wound care and replaced a dressing to R1's left lower leg.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 56 On August 2, 2022, at 11:23 a.m., ULP-C stated staff at the facility had been assisting R1 with dressing changes and wound cares since R1 was admitted February 10, 2022. R1's record lacked a signed prescriber order for wound care or compression treatments and therapy to R1's lower legs. On August 2, 2022, at 10:05 a.m., RN-A verified there was no signed order for the treatments being performed to R1's legs. On August 2, 2022, at 10:16 a.m., LALD-B acknowledged orders were required for treatments to R1's legs. LALD-B stated they had attempted to get orders from the physical therapist, but were told they should get the orders from R1's physician. LALD-B indicated they were still working on getting the orders. The licensee's undated Treatment and Therapy Management Plan policy indicated, "[Treatment] services will be provided under the orders of an authorized prescriber. The facility will request orders based on the individual resident needs, provide treatments or therapy, education to residents, and document services provided and communication with prescribers." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	08/02/2022

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03090	Continued From page 57 visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 1, 2022, at approximately 10:15 a.m., upon entrance to the facility, the surveyor observed the facility's front door and common areas and noted the lack of the required posting of the electronic monitoring notice to visitors. On August 1, 2022, at approximately 10:56 a.m., during the entrance conference, licensed assisted living director (LALD)-B, and house manager (HM)-D verified the licensee did not have an	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 58 electronic monitoring notice to visitors sign posted near the entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *08/02/22*
Time: 09:00:00
Report: 8087221180

Food and Beverage Establishment Inspection Report

Location:
Stanton House W Services Inc
4847 Bryant Avenue North
Minneapolis, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0037880
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125219543
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THERE ARE NO CHLORINE TEST STRIPS TO TEST THE CONCENTRATION OF THE CHLORINE SANITIZER SOLUTIONS. PROVIDE AN APPROPRIATE TEST KIT AS DESCRIBED IN THE ABOVE RULE.

Comply By: 08/12/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 10/01/22

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: HOT DOG
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: SOUP
Temperature: 41 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 11 Degrees Fahrenheit - Location: WHIRLPOOL FREEZER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II RENEE ANDERSON.

CABINETS ARE HARDWOOD, FLOORS ARE LAMINATE AND CEILING APPEARS TO BE TEXTURED AND NOT EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

FRIGIDARE BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. DISHWASHER IS OUT OF ORDER. 3 COMPARTMENT BIN SYSTEM BEING USED BUT NO CHLORINE TEST STRIPS AVAILABLE FOR SANITIZER CONCENTRATION MEASUREMENTS.

REFRIGERATOR IS WHIRLPOOL BRAND, GAS STOVE/RANGE IS SAMSUNG BRAND, AND MICROWAVE IS FRIGIDARE.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A SINGLE BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO RENEE ANDERSON.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087221180 of 08/02/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

DONITA BARROW
AGENCY LEAD

Signed:_____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us