



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

November 5, 2024

Licensee
Athanor Housing
266 Winifred Street East
Saint Paul, MN 55107

RE: License Number 414548
Health Facility Identification Number (HFID) 33679
Project Number(s) SL33679015

Dear Licensee:

On September 26, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed March 22, 2024. The follow-up survey found the facility to be in substantial compliance **Based on these findings, the condition(s) on the license were removed effective November 5, 2024.**

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 22, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on March 22, 2024, found not corrected at the time of the follow-up survey and/or subject to a penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - \$500.00
1530-Training In Dementia Care Required-144g.64 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on September 26, 2024, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on September 26, 2024, we identified the

following violation(s):

0470-Minimum Requirements-144g.41 Subdivision 1

0700-Resident Record-144g.43 Subdivision 1

1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)

1810-Medications; Over-The-Counter Drugs; Dietary-144g.71 Subd. 12

1880-Storage Of Medications-144g.71 Subd. 19

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/26/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING			STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33679015-2 On September 23, 2024, through September 26, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 30, 2024. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued/issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

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0 470	Continued From page 2 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 September 23, 2024, at 10:05 a.m., the surveyor inquired to registered nurse (RN)-B where the staffing plan was located. RN-B stated they did not create a staff planning and were unaware a staffing plan had to be created, signed, and evaluated by the clinical nurse supervisor (CNS). RN-B stated they did not know the specific requirements for the staffing plan but identified themselves as the CNS for the licensee. On September 23, 2024, at 10:09 a.m., licensed assisted living director (LALD)-A stated they were responsible for scheduling staff for the assisted living facility (ALF). LALD-A stated they forgot the staffing plan had to be created, signed, and evaluated by the CNS. On September 26, 2024, at 1:13 p.m., LALD-A stated one unlicensed personnel (ULP) worked per shift and the shift schedule was 6:00 a.m., until 2:30 p.m., 1:30 p.m., until 10:00 p.m., and 9:30 p.m., until 6:15 a.m. The CNS was available 24 hours per day, seven days per week. The licensee's 4.06 Staffing and Scheduling policy dated April 1, 2024, indicated the clinical nurse supervisor would develop and implement a staffing plan that provides an adequate number of qualified staff to meet the residents needs	0 470			

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0 470	Continued From page 3 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{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 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	{0 660}			

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{0 660}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) with evidence of a complete TB screening for one of three employee (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on March 9, 2024, to provide direct care services to residents. ULP-F's employee file lacked: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. On September 23, 2024, at 1:54 p.m., licensed assisted living director (LALD)-A stated they would ask employees to provide family and medical history to the licensee upon hire. LALD-A stated they were aware of the requirement to complete the baseline individual TB risk assessment. LALD-A stated there was no reason for it not being completed and that it was an	{0 660}			

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{0 660}	Continued From page 5 oversight. The licensee's 4.05 Employee Records policy dated April 1, 2024, indicated the licensee required verification health screenings for TB be completed with including dates. The licensees 8.16 Tuberculosis Screening the licensee would follow infection control practices related to TB according to the Center for Disease Control (CDC) The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, recommended all United States health care personnel should be screened for TB upon hire. No further information was provided.	{0 660}			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three resident's (R3, R5, R6) personal health and medical information was kept private.	0 700			

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0 700	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted on February 2, 2022, and began receiving assisted living services. R5 was admitted on July 15, 2024, and began receiving assisted living services. R6 was admitted on January 31, 2024, and began receiving assisted living services. On September 24, 2024, at 9:08 a.m., the surveyor observed registered nurse (RN)-B obtain a set of keys from an unlocked kitchen drawer in the upper part the split-level home that consisted of a common area, a combined kitchen and dining area, a hallway leading to a bathroom and three resident rooms. The surveyor observed RN-B use the keys to gain access to the pantry which held resident medications and a white binder. After the surveyor had looked through the medications, RN-B put the medications back into the pantry, locked the key lock, and placed the keys back into the kitchen drawer. RN-B walked downstairs. There were no staff or residents present. The keys were left unsecured. On September 24, 2024, at 9:12 a.m., with the keys unsecured in the kitchen drawer, unlicensed personnel (ULP)-H pushed R6 in a wheelchair from the resident's bedroom to the common area.	0 700			

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0 700	Continued From page 7 On September 24, 2024, at 9:22 a.m., with the keys unsecured in the kitchen drawer, and with R6 in the common area, ULP-H walked to the bathroom. There were no other staff present. On September 24, 2024, at 9:24 a.m., with the keys unsecured in the kitchen drawer, ULP-H walked from the bathroom to the kitchen. On September 24, 2024, at 9:45 a.m., with the keys unsecured in the kitchen drawer, the surveyor observed ULP-H take R6 from the common room to their room. The keys were unsecured in the kitchen drawer. There were no other staff present. On September 24, 2024, at 9:50 a.m., with the keys unsecured in the kitchen drawer, ULP-H returned to the dining area and sat down. On September 24, 2024, at 1:23 p.m., the surveyor observed RN-B remove the white binder from the pantry. The white binder contained resident information. For R3, R5, and R6 there was a face sheet that included the services received, medications, and a vulnerability assessment. RN-B stated resident medical information should be secured and it was an oversight for medication documentation to be left unsecured. On September 24, 2024, at 1:27 p.m., licensed assisted living director (LALD)-A stated they were responsible for ensuring resident medical information was kept secure. LALD-A stated the binder should not have been left unsecured. The licensee's 2.12 Confidentiality policy dated April 1, 2024 indicated the licensee would keep medical information private, except for the	0 700			

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0 700	Continued From page 8 following situations, "As may, be required by law, to other staff as appropriate or necessary to provide services, to persons authorized in writing by the resident or resident's responsible person to receive the information, including third party payers, or to representatives of the commissioner authorized to survey or investigate any part of the community." No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
{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	{0 810}			

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{0 810}	Continued From page 9 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: Not reviewed during this survey.	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. This had the	{0 820}			

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{0 820}	Continued From page 10 potential to directly affect all residents, staff, and employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 25, 2024, at 1:55 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. The posted floor plan labeled both the front and side doors as exits. 2. A keypad lock was installed on an interior door in the dining room. "Don't lock" was written on a piece of paper secured to the keypad with tape. When this dining room door was opened it led to a side door with an exit sign posted over it. During the facility tour interview on September 25, 2024, LALD-A stated the battery had been removed from the keypad lock and demonstrated the door was not locked. LALD-A opened the battery compartment and the surveyor verified a battery was not installed but wires for the battery were still attached. LALD-A stated they would cut the wires for the keypad battery and the wires were cut while the surveyor was still onsite. 3. A swing bar guard was installed above the thumb turn deadbolt lock on the front door. Emergency exit doors must unlock in a single operation. During the facility tour interview on September 25, 2024, LALD-A stated they would take off the swing bar guard and it was removed	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/26/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(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
{0 820}	Continued From page 11 while the surveyor was still onsite. The improper use of door-locking hardware on a door that is part of the egress path would limit the ability of occupants to safely exit the building in the event of an emergency. During the facility tour interview on September 25, 2024, LALD-A verified the installation of the locking hardware installed on the exit doors. LALD-A stated a consultant had recommended the front and side doors be designated as emergency exits and verified these doors were labeled as exits on the floor plan.	{0 820}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 12 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on March 9, 2024, and began to provide direct care and services to residents. ULP-E's employe record included five and one and three quarters hours of initial dementia care training completed in March 2024. The employee record lacked the required eight hours of dementia training to be completed within 160 hours of employment. ULP-G	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 13 ULP-G was hired on March 9, 2024, and began to provide direct care and services to residents. ULP-G's employe record included four and one and three quarters hours of initial dementia care training completed in June 2024. The employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. On September 23, 2024, at 1:14 p.m., licensed assisted living director (LALD)-A stated there was no other training records for ULP-F. LALD-A stated Educare (a training company for staff) assigned the classes to be completed. The surveyor inquired to LALD-A if they checked the assigned training by Educare met the training statutory requirement, LALD-A stated he wanted to decline answering, "I will get fined, regardless." LALD-A stated they were aware of the training requirement. The licensee's 5.03 Dementia Training policy dated April 1, 2024, indicated direct care employees will complete eight hours of initial training with 160 hours of the employment start date. No further information was provided.	{01530}			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640			

Minnesota Department of Health

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01640	Continued From page 14 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (R5). 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: R5 was admitted on July 15, 2024, and began	01640			

Minnesota Department of Health

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01640	Continued From page 15 receiving assisted living services. R5's diagnoses included generalized anxiety disorder, hearing loss, hypertension (high blood pressure), hyperlipidemia (high cholesterol), chronic tension-type headache, irritable bowel syndrome, chronic cerebrovascular accident (strokes), subcortical infarction (tissue death), cervical spondylosis (spinal neck cartilage is deteriorating), atrial fibrillation (abnormal heart rhythm), sinus tachycardia (fast heart rate), intraparenchymal hematoma of the brain (bruising on the brain), stroke, hypersomnia (excessive sleeping), and major depressive disorder. R5's Service Plan Agreement indicated R5 received assistance with activities, bathing, laundry, and safety checks. This document lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services. On September 24, 2024, at 11:52 a.m., registered nurse (RN)-B stated the Service Plan Agreement should be signed by the licensee and resident. RN-B stated they did not know why the resident or licensee had not signed the Service Plan Agreement. On September 24, 2024, at 12:07 p.m., licensed assisted living director (LALD)-A stated the Service Plan Agreement should have been signed by the licensee and the resident. LALD-A stated it was missed as staff were over worked. The licensee's 6.08 Service Plan dated April 1, 2024, indicated residents will have a service plan in place, and will include a signature or other authentication by (licensee name) and by the	01640			

Minnesota Department of Health

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01640	Continued From page 16 resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over the counter (OTC) drugs were up to date and stored as appropriate for three of three residents (R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01810			

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01810	Continued From page 17 The findings include: On September 24, 2024, at 9:08 a.m., in the locked pantry, the surveyor observed a white plastic bucket with the label, "stock medications for residents." The bucket contained the following expired medications: antibiotic ointment expired December 2021, Visine eye drops expired March 2023, petroleum jelly expired December 2024, smooth dissolving antacid 750 milligram expired July 2024, and lidocaine plus 4 percent (%) expired April 2024. On September 24, 2024, at 10:15 a.m., via the language line interpreter, unlicensed personnel (ULP)-H stated the medications in the white bucket were for residents on an as needed basis. ULP-H stated they were trained to look at the expiry dates on medications before giving them to residents. On September 24, 2024, at 10:27 a.m., registered nurse (RN)-B stated the medications in the white bucket were used for residents, and the RN was responsible for ensuring there were no expired medications. RN-B stated it was an oversight and there should not be expired medications for residents. On September 24, 2024, at 11:28 a.m., licensed assisted living director (LALD)-A stated the medications in the white bucket were for residents and ULPs were trained to look at expiry dates before administering medications. LALD-A stated there should not be expired medications and was not sure why there was expired medications in the bucket. LALD-A stated those medications should have been removed and disposed of.	01810			

Minnesota Department of Health

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01810	Continued From page 18 The licensee's 7.23 Medication Disposal policy dated April 1, 2024, indicated the license would dispose of expired medications according to accepted practices of the Minnesota board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, at 9:08 a.m., the	01880			

Minnesota Department of Health

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01880	Continued From page 19 surveyor observed registered nurse (RN)-B obtain a set of keys from an unlocked kitchen drawer in the upper part the split-level home that consisted of a common area, a combined kitchen and dining area, a hallway leading to a bathroom and three resident rooms. The surveyor observed RN-B use the keys to gain access to the pantry which held resident medications and a white binder. After the surveyor had looked through the medications, RN-B put the medications back into the pantry, locked the key lock, and placed the keys back into the kitchen drawer. RN-B walked downstairs. There were no staff or residents present. The keys were left unsecured. On September 24, 2024, at 9:12 a.m., with the keys unsecured in the kitchen drawer, unlicensed personnel (ULP)-H pushed R6 in a wheelchair from the resident's bedroom to the common area. On September 24, 2024, at 9:22 a.m., with the keys unsecured in the kitchen drawer, and with R6 in the common area, ULP-H walked to the bathroom. There were no other staff present. On September 24, 2024, at 9:24 a.m., with the keys unsecured in the kitchen drawer, ULP-H walked from the bathroom to the kitchen. On September 24, 2024, at 9:45 a.m., with the keys unsecured in the kitchen drawer, the surveyor observed ULP-H take R6 from the common room to their room. The keys were unsecured in the kitchen drawer. There were no other staff present. On September 24, 2024, at 9:50 a.m., with the keys unsecured in the kitchen drawer, ULP-H returned to the dining area and sat down.	01880			

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01880	Continued From page 20 On September 24, 2024, at 9:53 a.m., the surveyor observed ULP-H remove the keys from the kitchen drawer and unlock the pantry. On September 24, 2024, at 9:58 a.m., the surveyor observed ULP-H lock the pantry and place the keys back into the drawer. On September 24, 2024, at 10:04 a.m., via the language line interpreter, ULP-H stated they were trained not to leave the keys in the drawer by the RN. ULP-H stated they placed the keys into the drawer as they were being observed by Minnesota Department of Health (MHD) staff. ULP-H stated they did not let the resident observe where the keys were placed. On September 24, 2024, at 10:28 a.m., RN-B stated they trained staff to lock the pantry and to leave the keys in the drawer. RN-B stated there were staff, "usually right in that area." which would ensure the keys were supervised. RN-B stated the keys should have not been left unsupervised by staff. On September 24, 2024, at 11:31 a.m., licensed assisted living director (LALD)-A stated medications should be secured at all times and staff were trained to leave the key in the drawer. The surveyor inquired to LALD-A how the keys were secured when placed in the drawer. LALD-A stated, "its not." LALD-A then stated staff were trained to carry the keys at all times, and the key should not have been left in the drawer. The licensee's 7.11 Medication Storage policy dated April 1, 2024, indicated the licensee would only allow authorized staff to have access to medications.	01880			

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01880	Continued From page 21 No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 11, 2024

Licensee
Athanor Housing
266 Winifred Street East
Saint Paul, MN 55107

RE: Conditional License Number 414548
Health Facility Identification Number (HFID) 33679
Project Number(s) SL33679015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on May 30, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **October 9, 2024**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 22, 2024, found not corrected at the time of the May 30, 2024, follow-up and/or subject to penalty assessment are as follows:

- 0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - \$500.00**
- 0580-Quality Management-144g.42 Subd. 2 - \$500.00**
- 0640-Posting Information For Reporting Suspected C-144g.42 Subd. 7 - \$500.00**
- 0650-Employee Records-144g.42 Subd. 8 - \$500.00**
- 0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00**
- 0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00**
- 0730-Contents Of Resident Record-144g.43 Subd. 3**
- 0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) - \$500.00**
- 0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00**
- 0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)**
- 0950-Designation Of Representative-144g.50 Subd. 3**
- 1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4**
- 1470-Content Of Required Orientation-144g.63 Subd. 2 - \$500.00**
- 1500-Required Annual Training-144g.63 Subd. 5 - \$500.00**
- 1530-Training In Dementia Care Required-144g.64 - \$500.00**

1620-Initial Reviews, Assessments, And Monitoring- 144g.70 Subd. 2 (c-e) - \$500.00

3090-Notice To Visitors-144.6502, Subd. 8

The details of the violations noted at the time of this follow-up survey completed on May 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 30, 2024, we identified the following violation(s). MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$6,500.00. **MDH is not imposing these fines against your license at this time.**

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)

1170-Notice Required-144g.56 Subd. 3

1180-Consent Required-144g.56 Subd. 4

1290-Background Studies Required-144g.60 Subdivision 1 - \$3,000.00

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$3,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

The total amount you are assessed is 6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration

process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:

MDH will issue Athanor Housing a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Athanor Housing is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Athanor Housing will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Athanor Housing must provide the Department:
 - i. A list of the names and birthdates of any individuals Athanor Housing is currently in the process of admitting. These individuals will be able to

continue the admittance process.

- ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Athanor Housing will contract with an RN to provide consultation concerning all resident(s) to whom Athanor Housing provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Athanor Housing. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Athanor Housing and MDH must review the RN's credentials and approve the selection. Athanor Housing is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Athanor Housing in an effort to help Athanor Housing align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Athanor Housing will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Athanor Housing and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Casey.DeVries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to

them;

- v. Overall impressions about the quality of the assisted living services delivered;
- vi. Overall impressions about the dignity with which the residents and their family members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Athanor Housing to correct the violations cited during the follow-up survey as well as to determine the overall practice of Athanor Housing in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up survey: At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Athanor Housing will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

- i. A statement of the concern
- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Athanor Housing is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Athanor Housing is in substantial compliance on the follow up survey, MDH will remove the conditions from Athanor Housing's assisted living facility license, and Athanor Housing will correct any outstanding violations identified during the survey. If Athanor Housing is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license

under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>**.

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

If you have any questions, please contact Casey DeVries directly at: Casey DeVries.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/30/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING			STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33679015-1 On May 28, 2024, through May 30, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 22, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued. An immediate correction order was identified on May 29, 2024, issued for SL33679015-1, tag identification 2310. The immediacy of 2310 was not removed at the time of exit on May 30, 2024. An immediate correction order was identified on May 29, 2024, issued for SL33679015-1, tag identification 1290.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 000}	Continued From page 1	{0 000}			
0 340 SS=F	On May 30, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. 144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, during a follow up survey, the licensee failed to produce	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 documentation of any action taken to comply with correction orders issued on March 18, 2024, by the Minnesota Department of Health (MHD). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion of the POC, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 30, 2024, at 8:45 a.m., LALD-A stated the POC was being completed by another nurse (NSP-E), that worked out of the country. LALD-A stated the nurse was located in the Philippines and did not hold a Minnesota nurse license. On May 30, 2024, at 9:05 a.m., registered nurse (RN)-B stated they were aware NSP-E worked on the POC and was not located in the United States.	0 340			

Minnesota Department of Health

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0 340	Continued From page 3 On May 30, 2024, at 9:56 a.m., LALD-A stated the POC was not finished, and they should have completed and implemented the corrections from the previous MHD survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 340			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	{0 580}			

Minnesota Department of Health

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{0 580}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include: On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 1:35 p.m., LALD-A stated they were aware of the requirement for implementing a quality management program for the assisted living facility (ALF) and they were in the process of creating one.	{0 580}			

Minnesota Department of Health

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{0 580}	Continued From page 5 The licensee's undated Quality Improvement policy indicated the licensee would develop a performance improvement process and keep the documentation of that process on file for two years. The licensee lacked a current policy that referenced Minnesota Statutes 144G for Assisted Living licensure. No further information was provided.	{0 580}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a	{0 640}			

Minnesota Department of Health

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{0 640}	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on May 28, 2024, 9:30 a.m., the surveyor observed a landline telephone in the common room on the main level of the two-story house. There was no 911 posting near the landline telephone. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 28, 2024, at 11:18 a.m., LALD-A stated they had not posted the required information as they were transitioning to an electronic display for all notices. On May 28, 2024, at 11:47 a.m., registered nurse (RN)-B stated the landline telephone was used by residents. On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation.	{0 640}			

Minnesota Department of Health

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{0 640}	Continued From page 7 The licensees 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated June 2021 indicated 911 should be posted near landline telephones used by residents. No further information was provided.	{0 640}			
{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 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content to include an	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 8 annual performance evaluation for two of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: RN-B RN-B was hired on February 1, 2021, to provide supervision and direct care services to residents. RN-B's employee record did not contain any performance evaluations. ULP-D ULP-D was hired on June 7, 2020, to provide direct care services to residents. ULP-D's employee record did not contain any performance evaluations. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been	{0 650}			

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{0 650}	Continued From page 9 completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 30, 2024, at 1:02 p.m., RN-B stated they had not received an annual performance evaluation after the survey conducted by Minnesota Department of Health (MDH) in March 2024. On May 30, 2024, at 1:18 p.m., LALD-A stated they were aware of the required annual evaluation requirement for every member of staff, however, had not complete the required annual evaluations. The licensee's 4.35 Employee Evaluation policy dated June 2021, indicated [licensee] would conduct employee evaluations annually for all staff. No further information was provided.	{0 650}			
{0 660} SS=F	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 volunteers. The commissioner shall provide technical assistance regarding implementation of	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 10 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a facility TB risk assessment. 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: The licensee lacked a completed TB risk assessment for the facility. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 28, 2024, at 12:54 p.m., registered nurse (RN)-B stated the TB risk assessment was only performed on residents and a TB risk assessment was not completed for the facility. On May 29, 2024, at 8:35 a.m., LALD-A stated	{0 660}			

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{0 660}	Continued From page 11 they were responsible for the facility TB risk assessment and were behind in completing the requirement. On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. The licensee's 8.16 Tuberculosis Screening policy dated June 2021, indicated [licensee] would establish and maintain a comprehensive tuberculosis infection control program and the assessment would be updated annually based on data provided by the Minnesota Department of Health. No further information was provided.	{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	{0 680}			

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{0 680}	Continued From page 12 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated January 2014 lacked evidence of the following required content: - EP plan reviewed and updated annually; - a description of the population served by the licensee; - quarterly review of missing resident policy; - communication plan containing all required	{0 680}			

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{0 680}	Continued From page 13 elements; - hazard vulnerability assessment; - process for emergency plan collaboration; - subsistence needs for staff and residents; - procedures for tracking evacuated residents and staff; - policies for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy and needs; - long term care family notifications; - emergency prep training program which includes maintain documentation of all EP training and EP training annually; and - emergency preparedness testing requirements. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 28, 2024, at 11:26 a.m., registered nurse (RN)-B stated the licensee's EPP was in a book format but was not at the facility. On May 28, 2024, at 11:50 a.m., licensed assisted living director (LALD)-A stated the EPP was not available to staff or residents. LALD stated the EPP might had been misplaced. On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they	{0 680}			

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{0 680}	Continued From page 14 were aware of the required timeframe to correct each citation. The licensee's undated Emergency Preparedness Plan-Appendix Z Compliance policy dated June 2021, indicated the licensee's emergency preparedness plan would include all the required elements of appendix Z. No further information provided.	{0 680}			
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	{0 730}			

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{0 730}	Continued From page 15 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a written discharge summary with the required contents for one of one discharged resident (R2). 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:	{0 730}			

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{0 730}	Continued From page 16 R2 was discharged from the facility on December 13, 2023. R2's diagnoses included depression. R2's record lacked documentation a discharge summary had been completed, to include the following: -a summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to	{0 730}			

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{0 730}	Continued From page 17 assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 30, 2024, at 8:16 a.m., registered nurse (RN)-B stated discharge documentation should be completed for each resident. RN-B stated they did not complete the documentation from the previous survey citation, as the resident had already discharged from [licensee]. On May 30, 2024, at 9:17 a.m., RN-B stated, "if it's not documented, it's not done, we need to improve." The licensee's undated Client Discharge Process indicated the discharge plan would be discussed with the resident physician or client/responsible party prior to discharge and the discharge plan should be created by the RN to include instructions regarding the residents ongoing care needs. No further information was provided.	{0 730}			
{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	{0 790}			

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{0 790}	Continued From page 18 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 install and maintain portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, at 5:30 p.m., survey staff toured the home with registered nurse (RN)-B. During the tour, survey staff observed the following: 1. The back of the tags attached to the portable fire extinguishers were blank. No records for monthly fire extinguisher inspections were provided. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 2. Tags or labels were not attached to the portable fire extinguisher in the basement living	{0 790}			

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{0 790}	Continued From page 19 room showing annual maintenance had been performed by certified service personnel. 3. Portable fire extinguishers were stored on the floor in the basement living room and main floor kitchen. During the facility tour interview on May 29, 2024, RN-B verified fire extinguisher inspections had not been completed as required and the improper installation of three fire extinguishers on the floor. No further information was provided.	{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 provide the physical environment in a continuous state of good repair and operation with regard to 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	0 800			

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0 800	Continued From page 20 or has the potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, at 5:30 p.m., survey staff toured the home with registered nurse (RN)-B. During the tour, survey staff observed the following: 1. The FSEP floor plan labels two windows as exits in basement storage rooms. The egress window was obstructed by a table in the storage room across from the office. The improper placement of furniture could delay exiting in the event of an emergency. When RN-B opened the egress window in this storage room, the window would not open fully to provide a minimum clear open width of at least twenty (20) inches. The window well cover obstructed the egress window and prevented it from fully opening. When window well covers are installed on egress windows, the cover must not interfere with the opening of the window in any way. During the facility tour interview on May 29, 2024, RN-B verified the egress window obstructions. 2. The electrical panel in the basement was obstructed by items being stored in front of the panel. Electrical panels must be accessible at all times. Blocking electrical panels may delay access in the event of an emergency. During the facility tour interview on May 29, 2024, RN-B verified the electrical panel obstruction. 3. In the basement office, there was a hole in the ceiling. 4. In the basement bathroom, tiles were missing on the floor of the shower. During the facility tour interview on May 29, 2024, RN-B verified the hole in the ceiling and missing floor tiles. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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{0 810}	Continued From page 21	{0 810}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			

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{0 810}	Continued From page 22 Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, at 5:30 p.m., survey staff toured the home with registered nurse (RN)-B. During the facility tour, survey staff observed the following: 1. The Fire Safety and Evacuation Plan for Athanor Housing and a floor plan were posted on the back of the front door. The FSEP floor plan for the main floor labeled four rooms as bedrooms. 2. Numbers were posted at each bedroom door, identified as 1, 2, 3, and 4. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to include room numbers identifying the location of resident bedrooms on the fire safety and evacuation floor plan. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed at resident sleeping room doors to provide efficient communication for exiting in the	{0 810}			

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{0 810}	Continued From page 23 event of a fire or similar emergency. The posted FSEP failed to provide specific fire protection procedures necessary for residents evident by limited instructions for residents to follow instructions of staff and use designated exits. The posted FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. The employee actions were limited to ensuring wheelchairs and evacuation chairs were available. Survey staff emailed the licensee on May 28, 2024, at 12:29 p.m., requesting the fire safety and evacuation plan (FSEP), fire safety and evacuation training documentation, and employee evacuation drill records for the facility with a deadline to submit the documentation no later than May 29, 2024, at 4:00 p.m. The documentation requested in this email was not received. An email read receipt from the licensee was received by survey staff on May 29, 2024, at 3:59 a.m. During the facility tour interview on May 29, 2024, survey staff requested fire safety and evacuation training documentation and employee evacuation drill records for the facility from RN-B. RN-B stated the training and drill documentation was not available and survey staff should contact the licensee to request this information. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon	{0 810}			

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{0 810}	Continued From page 24 hire and/or at least twice per year as evident by the lack of training documentation. No employee training records were provided. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a lack of documentation. No evacuation drill records were provided. No further information was provided.	{0 810}			
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	{0 820}			

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{0 820}	Continued From page 25 by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. This had the potential to directly affect a limited number of residents, staff, and employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 29, 2024, at 5:30 p.m., survey staff toured the home with registered nurse (RN)-B. During the tour, survey staff observed a keypad lock installed on an interior door in the dining room. This dining room door was locked and required entry of a code to open it during the facility tour. When the dining room door was opened it led to a side door with an exit sign posted over it. The improper use of this type of door-locking hardware on a door that is part of the egress path would limit the ability of occupants to safely exit the building in the event of an emergency. All paths of egress must provide unobstructed exiting. During the facility tour interview on May 29, 2024, RN-B verified the installation of a keypad lock requiring a code on this interior door leading to a door with an exit sign. RN-B stated these doors, and the basement were not used by residents only employees. Survey staff reviewed the floor plan posted on the front door and the side door	{0 820}			

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{0 820}	Continued From page 26 was not labeled as an exit. No further information was provided.	{0 820}			
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	{0 950}			

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{0 950}	Continued From page 27 Based on interview and record review, the licensee failed to ensure the assisted living contract included the notice of the resident's right to designate a representative for certain purposes, and a box to indicate if the resident declined to designate a representative, for three of four residents (R1, R3, R4). 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 R1 admitted to the licensee on November 7, 2023, and began receiving assisted living services. R3 R3 admitted to the licensee on February 25, 2022, and began receiving assisted living services. R4 R4 admitted to the licensee on May 20, 2022, and began receiving assisted living services. R1, R3 and R4's Assisted Living Contracts were signed on January 31, 2024, January 2, 2024, and January 2, 2024, respectively, and included statute statements from 144G.50 subd. 3., on page 18. The contracts lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain	{0 950}			

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{0 950}	Continued From page 28 purposes" notice. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 10:00 a.m., LALD-A stated they were unsure of the correct verbatim language for designated representative that should be included in the Assisted Living Contracts and did not "have a good reason" for not including the required language. The licensee's undated 1.08 Designated Representative policy indicated [licensee] would include verbatim language for designating a representative when the Assisted Living Contract is executed. No further information was provided.	{0 950}			
01170 SS=D	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer;	01170			

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01170	Continued From page 29 (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to: (1) conditions that render the resident's room or private living unit uninhabitable; (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a 30-day advance written notice to the resident and/or the resident's legal/designated representative, prior to initiating a transfer for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01170			

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01170	Continued From page 30 On May 28, 2024, at 12:17 p.m., the surveyor observed R4 present in room four on the upper level of the two-level home. In the room there was a hospital style bed with bilateral bedrails, there was a cell phone, blanket, pillow, and other personnel effects. On May 29, 2024, at 2:40 p.m., the surveyor observed room four contained a hospital style bed with bilateral bedrails, no linen on the mattress, one dining chair, and a rectangular floor mat. There were no longer any personal effects in the room. On May 30, 2024, at 7:47 a.m., in room three on the upper level of the two-level home, the surveyor observed R4 present with their personnel effects, and a hospital style bed without bedrails and with linen on the mattress. On May 30, 2024, at 7:55 a.m., via phone interpreter, the interpreter stated they were unable to understand R4's verbal responses. Registered nurse (RN)-B stated R4 had a diagnosis of aphasia (difficultly speaking). On May 30, 2024, at 7:58 a.m., the surveyor observed RN-B speaking with R4 in a non-English language. RN-B stated R4 complained about sleeping on a different mattress. On May 30, 2024, at 8:35 a.m., RN-B stated they had a verbal discussion with R4 related to relocating R4 to room three. RN-B stated they didn't think the verbal discussion should be documented. On May 30, 2024, at 8:38 a.m., licensed assisted	01170			

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01180	Continued From page 32 The facility may not transfer a resident without first obtaining the resident's consent to the transfer unless: (1) there are conditions that render the resident's room or private living unit uninhabitable; or (2) there is a change in facility operations as described in subdivision 5. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed obtain consent prior to transferring residents to a different location with the assisted living facility (ALF) for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 28, 2024, at 12:17 p.m., the surveyor observed R4 present in room four on the upper level of the two-level home. In the room there was a hospital style bed with bilateral bedrails, there was a cell phone, blanket, pillow, and other personnel effects. On May 29, 2024, at 2:40 p.m., the surveyor observed room four contained a hospital style bed with bilateral bedrails, no linen on the mattress, one dining chair, and a rectangular floor mat. There were no longer any personal effects in	01180			

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01180	Continued From page 33 the room. On May 30, 2024, at 7:47 a.m., in room three on the upper level of the two-level home, the surveyor observed R4 present with their personnel effects, and a hospital style bed without bedrails with linen on the mattress. On May 30, 2024, at 7:55 a.m., via phone interpreter, the interpreter stated they were unable to understand R4's verbal responses. Registered nurse (RN)-B stated R4 had a diagnosis of aphasia (difficultly speaking). On May 30, 2024, at 7:58 a.m., the surveyor observed RN-B speaking with R4 in a non-English language. RN-B stated R4 complained about sleeping on a different mattress. On May 30, 2024, at 8:35 a.m., RN-B stated they had a verbal discussion with R4 related to relocating R4 to room three. RN-B stated they didn't think the verbal discussion should be documented. On May 30, 2024, at 8:38 a.m., licensed assisted living director (LALD)-A stated they could not recall the required process for relocating a resident to a new room. LALD-A stated they failed to contact family members to discuss the relocation of R4 and that bedrails were no longer available for the resident. On May 30, 2024 at 9:08 a.m., RN-B stated they had a verbal discussion with R4 that the resident was relocated to room three because the bed did not have bedrails. RN-B believed this was a suitable response to the immediate order (I/O) issued to [licensee] related to the bedrails on May	01180			

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01180	Continued From page 34 29, 2024. The licensee failed to document consent from R4 prior to relocating the resident to a new room. On May 30, 2024, at 9:17 a.m., RN-B stated, "if it's not documented, it's not done, we need to improve." On May 30, 2024, at 10:01 a.m., LALD-A stated they relocated R4 without following 144G Statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01180			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 35 Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of seven employees (registered nurse (RN)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: RN-B was hired on February 1, 2021, to provide supervision to staff and direct care services to residents. RN-B's employee file contained a Minnesota Department of Human Resources Background Study Clearance dated January 20, 2021. The health facility identification number (HFID) listed on the background check was HFID 33085. On May 29, 2024, at 11:10 a.m., the surveyor observed the licensee's NETStudy 2.0 roster (web-based system used to submit background study requests to the Department of Human Services (DHS)) affiliated to licensee's health facility identification number (HFID) 33679, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, for RN-B. RN-B's record lacked a background study clearance letter for HFID 33679. Although there	01290			

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01290	Continued From page 36 was evidence the licensee had submitted a background study for RN-B in affiliation with the licensee's HFID 33679, the background study was expired and was no longer valid. On May 29, 2024, at 11:15 a.m., licensed assisted living director (LALD)-A stated HFID 33085 was a former comprehensive license and was closed in February of 2024 or 2023. LALD-A stated they were unsure if they could still access the background checks for HFID 33085, "that might be NETStudy 1.0, I don't know I have access." On May 29, 2024, at 11:20 a.m., the surveyor observed LALD-A attempting to log onto Department of Human Services website, but LALD-A was not able to gain access and stated, "I think it's the wrong username and password". On May 29, 2024, at 11:23 a.m., the surveyor observed LALD-A call the Department Human of Services. The representative from Department of Human Service stated they were unable to look up background checks on NETStudy 1.0, and only NETStudy 2.0 was available, "you don't have a current username." The phone call ended. On May 29, 2024. at 11:25 a.m., LALD-A stated they could only access background checks for NETStudy 2.0, and they could no longer access the previously run background studies for HFID 33085. LALD-A stated they could not remember the requirements for the COVID-19 background study eligible, "I'm drawing a blank." LALD-A stated employee background checks should be affiliated to the HFID, and [licensee] should be able to view background checks online for all employees. LALD stated there were personnel issues occurring when the COVID-19 background	01290			

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01290	Continued From page 37 studies expired. On May 29, 2024, at 11:35 a.m., the surveyor observed RN-B at the facility providing documentation for the current survey and interacting with residents. On May 29, 2024, at 12:14 p.m., LALD-A stated they did not have a printable schedule for RN-B, but RN-B was scheduled to work Mondays through Thursdays. On May 29, 2024, at 1:20 p.m., the surveyor observed on the Minnesota Board of Nursing website, which indicated RN-B was licensed May 2, 2017. On May 29, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and	01290			

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01290	Continued From page 38 - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensees 4.02 Background Studies dated June 2021, indicated background checks would be conducted on all employees, volunteers and contractors for [licensee]. No further information provided. TIME PERIOD FOR CORRECTION: Immediate On May 30, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290			
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	{01440}			

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NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(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
{01440}	Continued From page 39 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse completed delegated task supervision within 30 calendar days for one of two employees (unlicensed personnel (ULP)-D) who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired June 7, 2020, to provide direct care services for the licensee's residents. ULP-D's record lacked evidence a registered nurse conducted direct supervision of ULP-D within 30-days of performing delegated tasks. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A.	{01440}			

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{01440}	Continued From page 40 LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 30, 2024, at 1:04 p.m., registered nurse (RN)-B stated they observed ULPs perform cares on residents and signed documentation as proof ULPs were competent. On May 30, 2024, at 1:10 p.m., LALD-A stated the documentation was "missing" and stated staff members are trained based on [licensee] policy and they had no further comment. The licensee's 6.18 Supervision of Staff dated June 2021, indicated staff members who provide direct care services be supervised to verify care is being performed competently. No further information was provided.	{01440}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	{01470}			

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{01470}	Continued From page 41 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	{01470}			

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{01470}	Continued From page 42 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 interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-D, ULP-E, registered nurse (RN)-B). 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). ULP-D ULP-D was hired June 7, 2020, and provided direct care services to residents. ULP-D's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: Overview of Assisted Living statutes; Review of provider's policies and procedures; Handling emergencies and using emergency	{01470}			

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{01470}	Continued From page 43 services; Reporting maltreatment of vulnerable adults or minors; Assisted Living Bill of Rights; Handling of resident complaints, reporting of complaints, where to report; Consumer 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/service delivery. ULP-E ULP-E was hired March 29, 2024, and provided direct care services to residents. ULP-E's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: Overview of Assisted Living statutes; Review of provider's policies and procedures; Handling emergencies and using emergency services; Reporting maltreatment of vulnerable adults or minors; Assisted Living Bill of Rights; Handling of resident complaints, reporting of complaints, where to report; Consumer 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/service delivery. RN-B RN-B was hired on February 1, 2021, to provide	{01470}			

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{01470}	Continued From page 44 supervision and direct care services. RN-B employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: Overview of Assisted Living statutes; Review of provider's policies and procedures; Handling emergencies and using emergency services; Reporting maltreatment of vulnerable adults or minors; Assisted Living Bill of Rights; Handing of resident complaints, reporting of complaints, where to report; Consumer 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/service delivery. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 12:45 p.m., RN-B stated they had not completed any training since the survey conducted in March 2024 by Minnesota Department of Health (MHD).	{01470}			

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{01470}	Continued From page 45 On May 29, 2024, at 12:48 p.m., the surveyor asked LALD-A why RN-B had stated no training had been completed since the survey in March 2024 by MDH. LALD-A stated they were still working on the POC and, "I'm going to keep my mouth shut." On May 30, 2024, at 1:10 p.m., LALD-A stated staff members are trained based on [licensee] policy and they had no further comment. LALD-A continued to stated the documentation was "missing". The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated June 2021, indicated all staff members providing direct care for [licensee] must complete an orientation to assisted living facility (ALF) licensing and regulations before providing assisted living services to residents. No further information was provided.	{01470}			
{01500} SS=F	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	{01500}			

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{01500}	Continued From page 46 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	{01500}			

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{01500}	Continued From page 47 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 interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment, for two of three employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B). 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-D ULP-D was hired on June 7, 2020, to provide direct care services to residents. ULP-D's employee file lacked the following content: -reporting maltreatment of vulnerable adults or minors; -assisted Living Bill of rights; -infection control techniques; -effective approaches to use to problem solve when working with a residents challenging behaviors and how to communicate with residents who have dementia; -review of provider's policies and procedures; and	{01500}			

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{01500}	Continued From page 48 -principles of person-centered planning/service delivery. RN-B were hired on February 1, 2021, to provide supervision and direct care services to residents. RN-B's employee file lacked the following content: -reporting maltreatment of vulnerable adults or minors; -assisted Living Bill of rights; -infection control techniques; -effective approaches to use to problem solve when working with a residents challenging behaviors and how to communicate with residents who have dementia; -review of provider's policies and procedures; and -principles of person-centered planning/service delivery. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 12:42 p.m., LALD-A stated they had completed training with employees that included dementia training, care provider set but had not documented the training. On May 29, 2024, at 12:45 p.m., RN-B stated	{01500}			

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{01500}	Continued From page 49 they had not completed any training since the after the survey conducted in March 2024 by Minnesota Department of Health (MHD). On May 29, 2024, at 12:48 p.m., the surveyor asked LALD-A why RN-B had stated no training had been completed since the survey in March 2024 by MDH. LALD-A stated they were still working on the POC and, "I'm going to keep my mouth shut." The licensee's 5.06 Annual Required Staff Training policy dated June 2021, indicated staff that perform direct care services will complete at least eight hours of annual training for each 12 months of employment. No further information provided.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	{01530}			

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{01530}	Continued From page 50 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-D, ULP-E). In addition, the licensee failed to ensure a supervisor of direct-care employees received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one employee (registered nurse (RN)-B). 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-D ULP-D was hired June 7, 2020, and provided direct care services to residents.	{01530}			

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{01530}	Continued From page 51 ULP-D was required to complete the dementia training by June 27, 2020. ULP-D's employee record lacked documentation of a total of eight hours of the required dementia training completed within 160 hours of employment, including the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; and -communication skills. ULP-E ULP-E was hired March 29, 2024, and provided direct care services to residents. ULP-E was required to complete the dementia training by April 25, 2024. ULP-E's employee record lacked documentation of a total of eight hours of the required dementia training completed within 160 hours of employment, including the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; and -communication skills. RN-B RN-B was hired February 1, 2021, and provided direct services to residents, and supervision of unlicensed staff. RN-B was required to complete the dementia training by June 22, 2021.	{01530}			

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{01530}	Continued From page 52 RN-B's employee record lacked documentation of the required eight hours of dementia training to be completed with 120 hours of employment, including the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors, and; -communication skills. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 12:42 p.m., LALD-A stated they had completed training with employees that included dementia training but did not document the training. On May 29, 2024, at 12:45 p.m., RN-B stated they had not completed any training since the prior survey conducted in March 2024 by Minnesota Department of Health (MHD). On May 29, 2024, at 12:48 p.m., the surveyor asked LALD-A why RN-B had stated no training had been completed since the survey in March 2024 by MDH. LALD-A stated they were still working on the POC and, "I'm going to keep my	{01530}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/30/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(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
{01530}	Continued From page 53 mouth shut." The licensee's undated 4.18 Employee General Orientation policy indicated [licensee] all staff members upon hire would be oriented to the assisted living facility in accordance with State and Federal regulations. No further information provided.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 54 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 90 calendar days from the previous assessment for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). R3 R3 admitted to the licensee on February 25, 2022, and began receiving assisted living services. R3's diagnoses included Type II diabetes mellitus with chronic kidney disease. R3 Service Plan dated May 28, 2024, indicated R3 received services including activities, bathing, dressing, grooming, linen and laundry, transfer, safety check, and toileting. R3's medical record included Nurse Assessment dated September 26, 2023. The next 90-day assessment was completed on February 28, 2024, 155 days late. The next 90-day assessment after February 28, 2024, should have been completed on May 28, 2024. R4 R4 admitted to the licensee on May 20, 2022, and began receiving assisted living services.	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 55 R4's diagnoses include history of multiple cerebrovascular accidents (strokes). R4's Service Plan dated May 28, 2024, indicated R4 received services including activities, bathing, dressing, grooming, linen, ambulation, transfers, safety checks, and toileting. R4's medical record included Nurse Assessment dated November 22, 2023. The next 90-day assessment was completed on February 28, 2024, 98 days late. The next 90-day assessment after February 28, 2024, should have been completed on May 28, 2024. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. On May 29, 2024, at 10:04 a.m., registered nurse (RN)-B stated resident assessments should be completed with 90 days of the previous assessment or with a change of condition. RN-B stated the assessments were not completed on time as other priorities occurred and they had multiple duties to perform for [licensee]. The licensee's 6.01 Assessment, Reviews and Monitoring dated June 2021, indicated [licensee]	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 56 will conduct assessments every 90 calendar days from the late of the last assessment. No further information was provided.	{01620}			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R3, R4) that had hospital-style bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3's diagnoses included Type II diabetes mellitus with chronic kidney disease.	02310			

Minnesota Department of Health

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02310	Continued From page 57 R3's Service Plan dated May 28, 2024, indicated R3's services included activities, bathing, dressing, grooming, linen and laundry, transfer, safety check, and toileting. R3's Vulnerability Assessment Dated September 26, 2023, which indicated R3 had side rails and positioning devices in place. The assessment indicated the bedrail use related to weakness fatigue and R3 was a fall risk, and staff were to report any concerns with the side rail or bed positioning. R3's Side Rail Use Assessment Form dated September 26, 2024, indicated risk vs. benefits were discussed with family. On May 28, 2024, at 9:50 a.m., during the facility tour, the surveyor observed R3's bed with a single hospital bedrail installed on the right-hand side of the bed. There was a metal walking cane tied to the bedrail with a green cord in the middle of the bedrail. There were three sections to the bedrail. Starting from the left side of the bedrail, there were two open areas that measured five inches in length and 12 inches in height. The next section had five sections of openings that measured three-and one-half inches in length and the height was 18 inches. The third and last section open measured five inches in length and 12 inches in height. There were no identifying labels on the bedrail. R3's record lacked: -Documentation the bedrails were installed, used, and maintained per manufacturer's guidelines; -Documentation of the intended purpose of the bedrail; -Documentation of bedrails for areas of entrapment, stability, and correct installation, and;	02310			

Minnesota Department of Health

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02310	Continued From page 58 -Documentation of the bedrail zones of entrapment measurements. R4 R4's diagnoses included history of multiple cerebrovascular accidents (strokes). R4's Service Plan dated May 28, 2024, indicated R4's services included activities, bathing, dressing, grooming, linen, ambulation, transfers, safety checks, and toileting. R4's record included a Vulnerability Assessment dated March 27, 2024, which indicated R4 had side rails and bed mobility devices. The assessment indicated the bedrail was used related to right-sided weakness and falls risk. R4's record included a Side Rail Use Assessment Form dated January 9, 2024, indicated risks vs. benefits were discussed with the resident. On May 28, 2024, at 12:19 p.m., during a facility tour, the surveyor observed R4's electric bed with identical bilateral 1/4 length moveable hospital-style bedrails. There were three sections to the bedrails. The bedrails were solid plastic with a curved top edge and had three openings. The first opening measured eight inches in length, and the height was four inches. The next opening measured three inches length and five inches height. The next opening measured eight inches in length, and the height was four inches. The left bedrail was not steady on the bed and was loose. The right bedrail was firmly attached to the bedrail. There were no identifying labels on the bedrails. R4's record lacked: -Documentation the bedrails were installed, used,	02310			

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02310	Continued From page 59 and maintained per manufacturer's guidelines; -Documentation of the intended purpose of the bedrail; -Documentation of bedrails for areas of entrapment, stability, and correct installation; and, -Documentation of the bedrail zones of entrapment measurements. On May 29, 2024, at 8:29 a.m., registered nurse (RN)-B stated the registered nurse (RN) was responsible for the bedrail assessment, and it was "missed" for not following the manufactures guidelines for installation. RN-B stated they were following the assessment questions listed in the electronic medical record (EMAR). RN-B stated they just ensured the bedrail was "sturdy". RN-B stated the missed assessment information was an oversight. On May 29, 2024, 8:38 a.m., licensed assisted living director (LALD)-A stated the RN was responsible for the bedrail assessment and was aware of the required content for the bedrail assessment, "that's a failure on my part." On May 29, 2024, at 9:44 a.m., LALD-A stated the cane tied to R3's bedrail should, "not be like that". LALD-A stated the resident was particular about how their personal items are organized and does, "whatever she likes." The Food and Drug Administration's (FDA), A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310			

Minnesota Department of Health

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02310	Continued From page 60 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks);	02310			

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02310	Continued From page 61 - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 6.28 Side rail policy dated June 2021, indicated bedrails will be installed according to manufactures instructions and [licensee] will ensure the bedrail is safe for use by residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to 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	{03090}			

Minnesota Department of Health

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{03090}	Continued From page 62 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). During a facility tour on May 28, 2024, at 9:30 a.m., the surveyor did not observe electronic recording notices on the front entrance or the side door exit. On May 28, 2024, at 9:32 a.m., the surveyor called licensed assisted living director (LALD)-A. LALD-A stated they were currently traveling out of state and did not have access to the laptop that contained the plan of correction (POC). On May 28, 2024, at 11:18 a.m., LALD-A stated [licensee] had not posted the required information as they were transitioning to electronic display for notices. LALD-A stated they were working on getting the information displayed on the electronic tablet. On May 29, 2024, at 8:51 a.m., LALD-A stated they assigned non-staff personnel (NSP)-E to assist with the completion, however, none of the corrections from the previous survey had been	{03090}			

Minnesota Department of Health

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{03090}	Continued From page 63 completed or implemented. LALD-A stated they were aware of the required timeframe to correct each citation. The licensee's 2.15 Electronic Monitoring policy dated June 2021 indicated the [licensee] was required to post the following statement at each entrance, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 16, 2024

Licensee
Athanor Housing
266 Winifred Street East
Saint Paul, MN 55107

RE: Project Number(s) SL33679015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine

of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Renee L. Anderson". The signature is written in a cursive, flowing style.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: renee.l.anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33679015-0 On March 18, 2024, through March 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents, all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on March 19, 2024, issued for SL33679015-0, tag identification 0820. On March 20, 2024, the immediacy of correction order 0820 was removed.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 470	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents, volunteers, and the public, as required, potentially affecting 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	0 470			

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0 470	Continued From page 2 or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posted daily staffing schedule including: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff members' resident assignments or work location; and - be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On March 19, 2024, at 12:00 p.m., no posted staffing schedule was observed in any area of the facility. On March 19, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A stated that he often posted a daily staffing schedule, but did not post one on this date. A staffing schedule policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480			

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0 480	Continued From page 3 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident	0 580			

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0 580	Continued From page 4 services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include: On March 19, 2024, at 11:00 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated that he had not done any quality management program development or documentation, and he was not sure why he had not done it. The licensee's undated Quality Improvement policy indicated the licensee would develop a performance improvement process and keep the	0 580			

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0 580	Continued From page 5 documentation of that process on file for two years. The licensee lacked a current policy that referenced Minnesota Statutes 144G for Assisted Living licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 640			

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0 640	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on March 19, 2024, at approximately 12:00 p.m., the common areas shared by residents, staff, and visitors, and near telephones lacked the required posting of the 911 emergency number. On March 19, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A verified the licensee lacked posting of the 911 emergency number and stated that he was not aware of that requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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	0 650			

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0 650	Continued From page 8 performance evaluations. ULP-D ULP-D was hired June 7, 2020. ULP-D's employee record did not contain any performance evaluations. On March 20, 2024, at 2:00 p.m., licensed assisted living director (LALD)-A stated that performance evaluations for RN-B and ULP-D had not been done and he did not know why the evaluations had not been completed. The licensee's undated Employee Evaluation policy indicated a performance evaluation would be completed at least annually for each employee and the performance review would be maintained in each employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	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 9 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a facility TB risk assessment. 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: The licensee lacked a completed TB risk assessment. On March 19, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated that he had not completed a TB facility risk assessment and he was not aware that the licensee needed to do a TB facility risk assessment. The licensee's undated Tuberculosis Screening policy indicated the licensee would complete a community TB risk assessment annually.	0 660			

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0 660	Continued From page 10 The CDC, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005" dated December 30, 2005, indicated: The first and most important level of TB controls is the use of administrative measures to reduce the risk for exposure to persons who might have TB disease. Administrative controls consist of the following activities: - assigning responsibility for TB infection control in the setting; - conducting a TB risk assessment of the setting; - developing and instituting a written TB infection-control plan to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed TB disease; - ensuring the timely availability of recommended laboratory processing, testing, and reporting of results to the ordering physician and infection-control team; - implementing effective work practices for the management of patients with suspected or confirmed TB disease; - ensuring proper cleaning and sterilization or disinfection of potentially contaminated equipment (usually endoscopes); - training and educating HCWs regarding TB, with specific focus on prevention, transmission, and symptoms; - screening and evaluating HCWs who are at risk for TB disease or who might be exposed to M. tuberculosis (i.e., TB screening program); - applying epidemiologic-based prevention principles, including the use of setting-related infection-control data; - using appropriate signage advising respiratory hygiene and cough etiquette; and - coordinating efforts with the local or state health department.	0 660			

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0 660	Continued From page 11 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the	0 680			

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0 680	Continued From page 12 required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 19, 2024, at 12:00 p.m., the surveyor observed the licensee lacked an emergency disaster plan posted prominently. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - EP plan reviewed and updated annually; - a description of the population served by the licensee; - quarterly review of missing resident policy; - communication plan containing all required elements; - hazard vulnerability assessment; - process for emergency plan collaboration; - subsistence needs for staff and residents; - procedures for tracking evacuated residents and staff; - policies for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information;	0 680			

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0 680	Continued From page 13 - sharing information on occupancy and needs; - long term care family notifications; - emergency prep training program which includes maintain documentation of all EP training and EP training annually; and - emergency preparedness testing requirements. On March 19, 2024, at 12:00 p.m., licensed assisted living director (LALD)-A stated that he had not done anything for Appendix Z. LALD-A further stated that he did not have any good reason for not developing an EP plan. The licensee's undated Emergency Preparedness Plan-Appendix Z Compliance policy indicated the licensee's emergency preparedness plan would include all the required elements of appendix Z. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730			

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0 730	Continued From page 14 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete and provide to the resident, or their representative, or case worker a written discharge summary with the required	0 730			

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0 730	Continued From page 15 contents for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was discharged from the facility on December 13, 2023. R2's diagnoses included depression. R2's record lacked a service plan. A progress note in R2's record, entered by registered nurse (RN)-B and dated December 12, 2023, at 6:10 p.m., indicated R2's family found a new placement for R2 with a higher level of care and hospice care. The progress note read, "Will complete documentation and discharge." R2's record lacked documentation a discharge summary had been completed, to include the following: -a summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional	0 730			

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NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING			STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107		
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0 730	Continued From page 16 status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The postdischarge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. On March 20, 2024, at 11:00 a.m., RN-B stated she thought she had completed a discharge summary, but could not locate it. The licensee's undated Discharge Summary policy referenced Minnesota Statutes 144A.4794, Subd. 1 (14) and directed that a discharge summary be completed for clients discharged from the facility. The licensee lacked a current policy that referenced Minnesota Statutes 144G. for Assisted Living licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	0 780			

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0 780	Continued From page 18 toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed a smoke alarm was not installed in occupied resident bedroom two. The bracket on the ceiling for a hardwired smoke alarm was empty and the wire harness visible. During an interview on March 21, 2024, at 3:10 p.m., LALD-A verified the smoke alarm was missing during the tour and stated it had already been reinstalled. This was not visually verified by the surveyor. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and	0 790			

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0 810	Continued From page 21 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Survey staff emailed the licensee on the following dates requesting the fire safety and evacuation plan (FSEP), fire safety and evacuation training documentation, and employee evacuation drill records for the facility: March 18, 2024, at 3:36 p.m. with a deadline to submit the documentation no later than March 19, 2024, at 3:00 p.m. A response to this email was not received. March 20, 2024, at 9:38 a.m., with an extension deadline to submit the documentation no later than March 21, 2024, at 8:00 a.m. A response to this email was not received. On March 21, 2024, at 9:55 a.m., survey staff emailed the licensee stating the requested FSEP, training documentation, and drill records had not been received. During an interview with survey staff on March 21, 2024, at 3:10 p.m., LALD-A stated the FSEP would be emailed to survey staff before the end of the day. On March 21, 2024, at 11:05 p.m., the licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), a fire safety and evacuation training policy, and an employee evacuation drill policy for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a 9.06 Fire Policy dated January 1, 2022. This policy was a third-party consultant provided plan, and it was not updated	0 810			

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0 810	Continued From page 22 to meet the facility-specific layout and environmental risks. The FSEP fire policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The policy inappropriately referenced smoke compartment doors, fire sprinklers, and doors on magnetic holders. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP fire policy failed to provide specific fire protection procedures necessary for residents evident by limited instructions for staff to remove tenants from immediate danger by evacuating those closest to the fire and moving outwards. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. On March 21, 2024, at 11:05 p.m., LALD-A explained, via email, "We use a physical copy of AHI's Assisted Living & Assisted Living with Dementia Care Emergency Preparedness Manual (version 2022). We are currently in the process of migrating documentation and records to digital. I am unable to retrieve physical records at the moment. This is what I currently have for digital only. I understand I will be cited for any deficiencies as a result." TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. No employee training records were provided. During an interview on March 21, 2024, at 3:10 p.m., LALD-A stated employees were trained at	0 810			

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0 810	Continued From page 23 the time of hire and twice a year and would email documentation, if located. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided. During an interview on March 21, 2024, at 3:10 p.m., LALD-A stated residents were trained every 6 months, but forgot if these trainings had been recorded and would email documentation, if located. On March 21, 2024, at 11:05 p.m., LALD-A stated, via email, "We are currently in the process of migrating documentation and records to digital. I am unable to retrieve physical records at the moment. This is what I currently have for digital only. I understand I will be cited for any deficiencies as a result." Survey staff reviewed the documentation attached to the email and no training records were included. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a lack of documentation. No evacuation drill records were provided. During an interview on March 21, 2024, at 3:10 p.m., LALD-A stated fire drills were completed twice per year, documentation should be available for these drills and records would be emailed if located. On March 21, 2024, at 11:05 p.m., LALD-A stated, via email, "We are currently in the process of migrating documentation and records to digital. I am unable to retrieve physical records at the moment. This is what I currently have for digital only. I understand I will be cited for any deficiencies as a result." Survey staff reviewed	0 810			

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0 810	Continued From page 24 the documentation attached to this email and no evacuation drill records were included. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to ensure egress windows met the minimum opening size in four occupied resident bedrooms, and the licensee failed to properly maintain a designated exit door. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 820			

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0 820	Continued From page 25 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: Egress Windows: On March 19, 2024, at 11:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. The egress windows in resident bedrooms were opened and measured. The windows in bedrooms one, two, three, and four, did not meet the minimum opening width requirements for safe egress. The egress windows in bedrooms one, two, three, and four all measured 19.5 inches in width. One window in each resident bedroom must meet the minimum window opening size of 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). During the facility tour interview, LALD-A verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate During an interview, on March 20, 2024, at 1:45 p.m., LALD-A stated locking mechanisms had been removed on the egress windows and the width requirement was now met. On March 20, 2024, at 1:45 p.m., survey staff completed a second tour of the resident bedrooms with LALD-A. The egress windows in resident bedrooms were opened and measured. The windows in bedrooms one, two, three, and four, all measured 20 inches in width. The egress	0 820			

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0 900	Continued From page 27 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 900			

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0 900	Continued From page 28 only occasionally). The finding include: R1 was admitted on January 31, 2024. On March 20, 2024, at 12:35 p.m., R1's assisted living contract was requested from licensed assisted living director (LALD)-A. LALD-A retrieved some papers from his desk, took the papers to R1, and a few minutes later presented the papers to the surveyor. The papers were titled, "[Licensee] Housing and Residential Housing With Services Lease/Contract", and were signed by LALD-A and R1, but the signatures were undated. On March 20, 2024, at 12:43 p.m., the surveyor asked LALD-A if he had just created the contract and signatures on the contract, a few minutes prior, and LALD-A replied that he had just created the contract and obtained a signature from R1, "a few minutes ago". The licensee's undated Signing an Assisted Living Contract policy indicated an assisted living contract be completed and signed when a resident moves into the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950			

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0 950	Continued From page 29 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the notice of the residents right to designate a representative for certain purposes, and a box to indicate if the resident declined to designate a representative, for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 950			

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0 950	Continued From page 30 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's Housing and Residential Housing with Services Lease/Contract, effective January 4, 2024, lacked the verbatim notice of their right to designate a representative, and lacked a space for the resident to initial if the resident declined to indicate a designated representative. On March 20, 2024, at 12:43 p.m., licensed assisted living director (LALD)-A stated that he was not aware of the required notice language and area to decline a designated representative in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440			

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01440	Continued From page 31 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse completed delegated task supervision within 30 calendar days for one of one employee (unlicensed personnel (ULP)-D), who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired June 7, 2020, to provide direct care services for the licensee's residents. ULP-D's record lacked evidence a registered nurse conducted direct supervision of ULP-D	01440			

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01440	Continued From page 32 within 30-days of performing delegated tasks. On March 20, 2024, at 2:20 p.m., licensed assisted living director (LALD)-A stated the licensee had no records of direct supervision of ULP-D within 30-days of performing delegated tasks.. The licensee's undated Supervision of Staff - Delegated Services policy indicated all staff who performed a delegated task must have direct supervision performing the delegated task within 30 calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	01470			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(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
01470	Continued From page 33 support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 34 licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services, for two of two employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B). 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-D and RN-B were hired on June 7, 2020, and February 1, 2021, respectively. ULP-D and RN-B's employee records lacked documentation the following orientation topics were completed: -Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; -Review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; and -Review of the types of assisted living services the employee will provide, and the provider's scope of license. On March 20, 2024, at 2:20 p.m., licensed assisted living director (LALD)-A stated that he could not locate documentation that ULP-D and RN-B had received orientation to assisted living	01470			

Minnesota Department of Health
STATE FORM 6899 9EWL11 If continuation sheet 36 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER ATHANOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 266 WINIFRED STREET EAST SAINT PAUL, MN 55107			
(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
01500	Continued From page 36 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, 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 interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment, for two of two employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B).	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
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01500	Continued From page 37 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-D and RN-B were hired on June 7, 2020, and February 1, 2021, respectively. ULP-D and RN-B's records both lacked evidence of annual training provided since either employee was hired. On March 20, 2024, at 1:15 p.m., licensed assisted living director (LALD)-A stated that he provided an "annual training meeting" for employees, but did not document the content or attendance of that meeting. The licensee's undated Annual Required Staff Training policy indicated the licensee would provide and document all required topics for annual training in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
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01530	Continued From page 38 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of one employee (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure a supervisor of direct-care employees received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2024
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01530	Continued From page 39 employee (registered nurse (RN)-B). 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-D was hired June 7, 2020, and provided direct care services to residents. ULP-D's employee record lacked documentation of a total of eight hours of the required dementia training completed within 160 hours of employment, including the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; and -communication skills. RN-B was hired February 1, 2021, and provided direct services to residents, and supervision of unlicensed staff. RN-B's employee record lacked documentation of the required eight hours of dementia training to be completed with 120 hours of employment, including the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; and	01530			

Minnesota Department of Health

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01530	Continued From page 40 -communication skills. On March 20, 2024, at 2:20 p.m., licensed assisted living director (LALD)-A stated that he could not locate documentation that ULP-D and RN-B had received initial training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620			

Minnesota Department of Health

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01620	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessments to include a 14-day reassessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included: R1 was admitted to the licensee on January 31, 2024. R3's record included an admission assessment dated February 1, 2024, and a 14-day assessment dated February 28, 2024, 27 days after the start of services. On March 20, 2024, at 11 a.m., registered nurse (RN)-B stated she was the staff person responsible for resident assessments, she used Eldermark forms, and Eldermark gave her alerts when assessments were due. RN-B stated that this assessment, "just fell off my radar." The licensee's undated Assessments, Reviews & Monitoring policy directed nursing assessment or reassessment must include all the required elements of the uniform assessment tool, and reassessment and monitoring must be conducted	01620			

Minnesota Department of Health

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01620	Continued From page 42 no later than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was provided no later than 14 calendar days after the date that services were	01640			

Minnesota Department of Health

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01640	Continued From page 43 first provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 to the licensee on January 31, 2024. R1's diagnoses included chronic obstructive pulmonary disease (COPD, chronic inflammation causing decreased lung function). On March 20, 2024, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-C administer inhaled medication to R1. R1's record lacked a service plan. On March 20, 2024, at 11:00 a.m., registered nurse (RN)-B stated that she had not developed a service plan for R1 and explained that she used resident assessments as the service plans. The licensee's undated Service Plan policy indicated within 14 days after the date that services are first provided to a resident, the licensee would finalize a written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640			

Minnesota Department of Health

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01640	Continued From page 44 (21) days	01640			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to 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 March 19, 2024, at 10:00 a.m., upon entering the facility, the surveyor observed two entrances accessible by visitors to the facility, but each lacked the required notice for electronic monitoring.	03090			

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Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: 04/11/24
Time: 12:40:00
Report: 1039241110

Food and Beverage Establishment Inspection Report

Page 1

Location:

Athanor Housing
266 Winifred Street East
St Paul, MN55107
Ramsey County, 62

Establishment Info:

ID #: 0038123
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516000701
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 previously issued on 03/19/24 have NOT been corrected.

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.

NO TEST KIT FOR CHLORINE BLEACH IS PRESENT. ACQUIRE BLEACH TEST STRIPS. TESH STRIPS MUST MEASURE 10 TO 200 PPM CHLORINE.

Issued on: 03/19/24

Comply By: 04/02/24

2-100 Supervision

2-102.12AMN

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

NO STAFF ARE CURRENT CFPM. GUIDANCE DOCUMENT ON BECOMING CFPM SENT WITH THIS REPORT. 4/11/24 UPDATE - PER PERSON-IN-CHARGE, STAFF HAVE ENROLLED IN FOOD SAFETY COURSE.

Issued on: 03/19/24

Comply By: 05/03/24

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

CHLORINE RESIDUAL IN DISH WASHING MACHINE MEASURES <10 PPM. DISH MACHINE DELIVERS CHLORINE BLEACH BUT CONCENTRATION IN RINSE ISN'T HIGH ENOUGH TO SANITIZE. SEE GENERAL COMMENTS.

Comply By: 04/12/24

Type: Follow-Up
Date: 04/11/24
Time: 12:40:00
Report: 1039241110
Athanor Housing

Food and Beverage Establishment Inspection Report

Page 2

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

REGARDING VIOLATION OF MN Rule 4626.0735AB, DISH WASHING MACHINE MUST BE REPAIRED OR REPLACED SO THAT IT SANITIZES DISHES. UNTIL THEN, STAFF MUST SANITIZE DISHES IN SINK OR BY MANUALLY ADDING BLEACH TO A 2ND RUN OF DISH MACHINE SO THAT CHLORINE RESIDUAL MEASURES 50 TO 200 PPM.

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 1039241110 of 04/11/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Phineas Vang
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us

Type: Full
Date: 03/19/24
Time: 11:15:00
Report: 1039241077

Food and Beverage Establishment Inspection Report

Page 1

Location:

Athanor Housing
266 Winifred Street East
St Paul, MN 55107
Ramsey County, 62

Establishment Info:

ID #: 0038123
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516000701
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) **** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

SHELL EGGS STORED OVER READY-TO-EAT FOODS IN KITCHEN REFRIGERATOR. GUIDANCE DOCUMENT ON SEPARATING RAW ANIMAL FOOD FROM READY-TO-EAT FOOD SENT WITH REPORT. EGGS TO BE MOVED TO BASEMENT REFRIGERATOR.

Comply By: 03/19/24

4-700 Sanitizing Equipment and Utensils

4-702.11 **** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

BLEACH DISH WASHING MACHINE MEASURES 0 PPM CL2. ADJUST OR SERVICE MACHINE TO DELIVER BLEACH SANITIZING RINSE. AFTER SANITIZING WITH BLEACH, 1 COMPARTMENT OF SINK SHOULD BE USED FOR A BLEACH SANITIZING RINSE UNTIL DISH WASHING MACHINE IS FUNCTIONING.

Comply By: 04/02/24

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO PROBE-TYPE FOOD THERMOMETER. ACQUIRE A PROBE-TYPE DIGITAL FOOD THERMOMETER AND USE ALCOHOL WIPES TO SANITIZE PROBE BEFORE AND AFTER USE.

Comply By: 04/02/24

Type: Full
Date: 03/19/24
Time: 11:15:00
Report: 1039241077
Athanor Housing

Food and Beverage Establishment Inspection Report

Page 2

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.

NO TEST KIT FOR CHLORINE BLEACH IS PRESENT. ACQUIRE BLEACH TEST STRIPS.

Comply By: 04/02/24

2-100 Supervision

2-102.12AMN

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

NO STAFF ARE CURRENT CFPM. GUIDANCE DOCUMENT ON BECOMING CFPM SENT WITH THIS REPORT.

Comply By: 05/03/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

CONTAINERS OF RICE STORED ON KITCHEN FLOOR. INSTRUCTED STAFF TO ADD SHELVING OR RACKS TO COMPLY WITH ABOVE.

Comply By: 04/02/24

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit

Location: DISH WASHING MACHINE

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: CONGEE

Temperature: 38 Degrees Fahrenheit - Location: COLD HOLD KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: AMBIENT

Temperature: 41 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR

Violation Issued: No

Process/Item: MEATS

Temperature: Degrees Fahrenheit - Location: FROZEN IN FREEZER

Violation Issued: No

Process/Item: COOKED RICE

Temperature: 198 Degrees Fahrenheit - Location: HOT HOLD IN RICE COOKER/WARMER

Violation Issued: No

Type: Full
Date: 03/19/24
Time: 11:15:00
Report: 1039241077
Athnor Housing

Food and Beverage Establishment Inspection Report

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The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Robyn Woolley.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, tile floor, painted walls with popcorn ceiling and laminate countertops. There is a stainless steel backsplash behind the sink and adjacent counters.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator is of residential grade. There is an additional residential refrigerator and chest freezer in the basement.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A chlorine bleach dish washing machine is present in kitchen. See order regarding dish washing machine. Guidance document on dish washing sent with this report.

A supply of single-use gloves is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

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 1039241077 of 03/19/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Phineas Vang
person-in-charge

Signed: _____

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